North Carolina Pharmacist

Volume 82, Number 1 ...applying drug knowledge to improve health Winter, 2002

Medicaid Program Leaders Answer Our Questions

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Inside

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Fred Eckel
Executive Director

One Voice, One Vision or...

I entered pharmacy school in 1957 to hear that the profession was at a cross road. In my career the pharmacy profession has been at critical points many times. We haven't always made the right decisions as hindsight might suggest. Are we there again? NCAP came together to create a single voice for North Carolina pharmacy, thus our motto, "One Voice, One Vision." But do we have that now? Is NCAP becoming one voice, many visions or perhaps, even worse, North Carolina pharmacy is becoming many voices and many visions. I hope not. As new groups re-form or old groups never dissolve, I hope we can become many voices with one vision. For me, the pivotal issue today seems to be adequate dispensing fees and/or medication management reimbursement.

A Washington based pharmacy association leader said "I think that if the profession remains focused on drugs [adequate dispensing fees], what they cost, and how much we can discount them versus what happens to patients if they don't take them correctly [medication management], then we have a very limited future indeed. We become part of a commodity enterprise and in such, only wrenching cost from transaction is valued."

As some North Carolina pharmacy leaders focus on assuring adequate Medicaid pharmacy dispensing fees, I hope we don't find ourselves winning a battle to preserve an appropriate dispensing fee but losing the war to get pharmacists' reimbursement for medication management. Yes, adequate dispensing fees are important because we see drug dispensing as a means to assure medication management. When dispensing becomes the end activity, as it seems to be for too many pharmacists, what have we achieved with an adequate dispensing fee? At best a short-term victory, but is drug dispensing really pharmacy's future? I know many will disagree with me on this issue, but I feel strongly that cognitive services reimbursement is just as important as adequate dispensing fees, if not more important for our long-term future. Unless some pharmacy voice keeps raising this banner and works to achieve this future, we might find ourselves looking back on 2002 and saying once more, "pharmacy didn't make the right decision." Thus, NCAP will try to walk the line between promoting adequate dispensing fees and promoting medication management reimbursement. This will be hard to do because some may see this as a conflicting message and others may only see one side of our message as being important. However, NCAP is your organization. So, if you want us to take a different road let your Board members know your thoughts because I work for them, and for you. Until I am instructed differently, our voice will be adequate dispensing fees and medication management reimbursement. ❖

"Thank You" to NCAP's New President's Club Members

The North Carolina Association of Pharmacists would like to thank the following individuals who supported our Association this year with financial contributions above and beyond standard membership dues. Membership in NCAP's new President's Club requires a minimum donation of $95.

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Ross Brickley
President

Knowledge, Innovation and Emerging Practice Opportunities

Dear Members,

Pharmacists possess two types of knowledge. The first is external; it consists of what is known about our practice setting and its processes and procedures. It includes standards of practice, medical literature, white papers and databases. The other type of knowledge, internal, is hard to define; it's the knowledge that resides in our minds. Our formal education; successes and failures; our practice setting; the patients we serve; the organization that employs us; and pharmacy peers that leave lasting impressions mold internal knowledge.

There are two types of "innovation." One is "incremental" innovation, which helps to improve existing products, as in the different versions of DOS operating software for computers. The second is "discontinuous" innovation that alters industry standards and replaces existing products, as in the development of Windows software.

Studies suggest that 70% of all innovations are driven by market need rather than by a new concept, technique, or technology seeking a need. Some say that a majority of innovations in many industries are made by customers guiding or adding value to a producer's new concept. Customers with a genuine need tend to be more tolerant of the uncertainties inherent in the innovation process (I can still remember the first computer we installed in our retail pharmacy years ago—it had multiple software glitches but we patiently worked through them because we needed the speed and data collection capabilities of the computer).

So what's the best way to use our knowledge, coupled with innovation, to integrate our patients into emerging practice opportunities? Below we explore some ways to do this:

(A) Invite patient/customer input—now and over the long haul. Use "incremental" innovation described above to collaborate with customers on problems that both parties care about. For example, how can pharmacists use innovation to collaborate with patients and insurance payer sources to manage the rising cost of pharmaceuticals?

(B) Think "co-creation." Long-term relationships have powerful advantages in sustaining innovation. But customer-driven (i.e. patient-driven) innovation can occur on a much shorter time schedule. Can pharmacists take a step back from "normal practice methodologies;" take a macro view of the opportunities in healthcare and co-create new practice opportunities?

(C) Learn to recognize when customers can't say what they need. Patients and customers communicate with pharmacists all the time, whether or not we are aware of it. Paying particular attention to unspoken cues can mean the difference between success and failure. Observation thus becomes important like inquiry- the traditional means of assessing a patient's need.

What is to be learned here? The patients/customers would probably never have asked for this innovation. They might have believed it was not possible, their imaginations not stretching as far as needed to recognize the potential opportunities. As Margaret Wheatley is quoted in *Innovation Explosion*, "Innovation is fostered by disorderly information gathered from new connections; from insights gained from journeys into other disciplines and places." Have pharmacists thought "out of the box" on how to use the new Clinical Pharmacist Practitioner (CPP) rules to expand their practice opportunities?

(D) Take care that technology enhances rather than impedes the process. Do we sometimes rely so heavily on our software driven drug-interaction and drug-allergy screening components that we fail to assess the appropriateness of the drug therapy based on medical condition and age? Is it enough to "counsel patients" on their medication or do we need to go a step further and provide "medication management?" Which service option will provide the greatest impact for our patients?

The optimal strategy for bringing the patient/customer into the innovation process combines the spontaneity of observation (i.e. assessment) with the more formal process of inquiry. Pharmacists have the capability of capturing a wide variety of data, including qualitative and sensory cues. We can use this data to "reflect" on all of the patient's/customer's potential problems and needs. We can brainstorm for solutions and develop prototypes of possible solutions.

Tom Peters describes as the primary challenge of the next 10-15 years, "seeing who can go the farthest in empowering customers." Empowering customers, Peters explains, means giving them choices about the use of our resources, allowing them "to customize products and services provided by you to meet their specific needs."

NCAP is working diligently to empower pharmacists in all practice settings to do as Tom Peters describes above. In looking forward, NCAP has created a unified legislative lobbying force that is gaining momentum as we speak. At a recent national meeting in Washington DC, North Carolina was recognized for its effort and accomplishment in salvaging Medicaid reimbursement for pharmacists in the 2001 legislative session. The Education Council consists of representatives from the different practice forums who are working together to maximize the quality and scope of the educational sessions. The Professional Affairs Council is addressing workplace issues and exploring ways to improve practice opportunities for pharmacists. Finally, NCAP is an integral part of creative initiatives that can expand the practice and reimbursement opportunities for pharmacists in North Carolina. The Association is excited at the opportunity to collaborate with the members to co-create new practice opportunities and address reimbursement challenges in 2002.

Sincerely,
Ross Brickley, RPh, MBA, CGP, President

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NCAP Profiles NC Medicaid Program Leaders

Senator Tony Rand, Majority Leader

How did your career as a consultant prepare you to serve in the legislature?

The bulk of my career was spent as a lawyer. I believe the preparation and training that the legal profession provides is uniquely suited to legislative service. It also helps you see both sides of most problems and understand different positions. The training in reading and interpreting General Statutes is also very beneficial.

What is your opinion of pharmacy as a profession and how would you like to see pharmacy fit into the healthcare system/ Medicaid Program?

I have read that pharmacists are generally regarded as the most trustworthy professionals in our society. I believe this is true because all of us instinctively rely on the information and service provided to us. Pharmacists provide the most important cog in our healthcare system, because through them we receive proper medication and correct dosage. Without this service the rest of the entire system would fold.

Pharmacists have not received a dispensing fee increase since 1992 while other providers have received at least cost of living increases. Do you feel it was appropriate to reduce the pharmacists dispensing fee this year even though goods and services for everyone has increased in the last ten years?

Fee increases have been truly difficult during this period of economic downturn. In the State Health Plan and Medicaid Program we have been under tremendous pressure to reduce spending. I'm afraid pharmacists have had to bear the brunt of this because of our inability to do anything to the pharmaceutical companies. Hopefully we will be able to remedy this and bring some equality to the system. Protection and equity for our pharmacists is one of the most important things we can do.

Representative James B. Black, Speaker of the House

How did your training and practice as an optometrist prepare you for your legislative role?

My training in optometry taught me to gather data not only on patients' vision and eye health, but also on their general health. After gathering the data I determine the best prescription for that person. I use the same approach as a legislator. I gather all the data that I can on an issue and then I write a prescription.

I also have a better perspective on healthcare issues, including pharmacy, because of my profession. Very few legislators have a background in healthcare. We need more people in the Legislature with an understanding of what the healthcare system should be.

Finally, my practice keeps me in touch with a broad range of citizens. My patients are not shy about letting me know what they think about current issues and events.

What is your opinion of pharmacy as a profession and how would you like to see pharmacy fit into the healthcare system/ Medicaid Program?

Pharmacy should be held in higher regard in the field of healthcare. Pharmacists do more than put pills in a bottle. They play a vital and increasingly important role in today's healthcare system. With the growth of managed care, pharmacists are a valuable and accessible resource for patients.

I personally think that pharmacists should be more involved in healthcare management. Physicians of today are somewhat overloaded with data gathering because of the complexity of pharmaceutical agents being prescribed. So the pharmacists' role has become increasingly important.

Patient safety is at risk when pharmacists are not involved in their healthcare. That's why I have a great fear of the increasing trend of ordering pharmaceutical agents over the Internet. This is very dangerous for the citizens of our country.

Pharmacists have not received a dispensing fee increase since 1992 while other providers have received at least cost of living increases. Do you feel it was appropriate to reduce the pharmacists dispensing fee this year even though goods and services for everyone has increased in the last ten years?

I have worked very hard to improve the reimbursement fees for pharmacists and will continue to do so. It was not appropriate to reduce the pharmacists' dispensing fee, and I believe that your leadership will confirm my strong interest in the subject.

To help make their case, rank-and-file pharmacists must continue to develop relationships with members of the General Assembly. I have told groups over the years that the time to get to know your legislator is before you have a problem.

Carmen Hooker Buell, Secretary, Dept. of Health and Human Services

What is your educational background and career path that led you to your current position?

Prior to my appointment as Secretary of the NC Department of Health and Human Services, I served as Vice President of Government Relations for Quintiles Transnational Corporation in Research Triangle Park. I also served as the Group Vice President for Carolinas HealthCare System.

I was a Project Officer for the Milbank Memorial Fund, a New York based foundation that conducts non-partisan analysis, study, and research on significant issues in health policy.

Before coming to North Carolina in 1995, I served as a member of the Massachusetts House of Representatives for nearly 11 years. While in the legislature, I advocated for healthcare reform and children's health.

I am an Adjunct Professor at the UNC School of Public Health and a member of the North Carolina Institute of Medicine. I have a bachelor's degree in sociology and political science from Springfield College and a master's degree in regional planning from the University of Massachusetts at Amherst.

What is your opinion of pharmacy as a profession and how would you like to see pharmacy fit into the healthcare system/ Medicaid program?

Pharmacy is a vital part of our healthcare delivery system. Pharmacists employ a vast array of knowledge on drug therapies, pharmacology, and disease management. In this time of tight budgets and increasing Medicaid expenses, the Medicaid program looks to pharmacists for suggestions on cost containment, therapeutic interchange and substitutions, prior authorization, managing the use of high cost brand name drugs, establishing therapeutic limits based on appropriate dosage or usage standards, encouraging use of generic drugs when applicable, expanding disease management initiatives, and developing a preferred drug list.

What is the role of government in addressing the pharmacy needs of citizens?

It is up to government to try to address the basic healthcare needs of vulnerable populations. The continuing struggle is to temper that responsibility with good stewardship of public funds. State government has long played an important role in helping low income and other at-risk people with such needs as immunizations, controlling diabetes and managing mental illness.

One pressing issue that we have been unable to even begin to fill until now is the tremendous need of seniors for prescription drugs. With the help of the tobacco settlement money, that is about to change.

The new Prescription Drug Assistance Plan will help up to 100,000 seniors struggling to pay for their medication. According to a recent federal report, prescription drugs now account for about one-sixth of all out-of-pocket health spending for the elderly. For those with low incomes, these costs can be overwhelming.

A priority of Governor Easley's, the plan makes eligible those seniors with incomes less than $17,180 a year and couples with incomes less than $23,220. The plan will include treatment for three specific diseases: cardiovascular disease, diabetes mellitus, and chronic obstructive pulmonary disease. It is estimated that 71 percent of seniors suffer from at least one of these diseases. Seniors will be given an enrollment card to present to participating pharmacies giving them an annual 60 percent discount up to a maximum of $1,000. The program should be in place sometime this summer.

Sharman Leinwand, Pharmacy Program Manager, Division of Medical Assistance, DHHS

What is your educational background and career path that led you to your current position?

I attended UNC Chapel Hill School of Pharmacy and graduated with honors from the University of Tennessee, School of Pharmacy. My practice included many years in Hospital Pharmacy, County Health Department, Retail Pharmacy (pharmacy manager), and preceptor for both UNC School of Pharmacy and Campbell University School of Pharmacy. I received my Master's degree in Public Health—Health Policy and Administration—from UNC School of Public Health.

What is your opinion of pharmacy as a profession and how would you like to see pharmacy fit into the healthcare system/ Medicaid Program?

Pharmacy is a wonderful career pathway for individuals who have a desire to make a positive impact on healthcare. Pharmacists are knowledgeable with drug therapies, disease management and care initiatives, drug utilization, therapeutic substitution or interchange protocols, and most recently cost containment issues. My vision for community pharmacists; to become proactive players in healthcare outcomes; to participate with all healthcare disciplines to provide the best healthcare options to our recipient population. By participating in disease management initiatives, a strong partnership approach between patients, pharmacists, and physicians will develop improved healthcare outcomes while reducing total healthcare costs (i.e., decrease hospital use, LOS, lab, physician visits, ER visits, outpatient emergency visits). A disease management program can decrease inappropriate prescribing patterns and increase patient compliance with their treatment regimen. A stronger relationship among patients, pharmacists, and physicians might be the best approach to improving outcomes for such chronic diseases as diabetes, hypertension, CHF, asthma, dyslipidemia, GI disorders, depression, chronic lung disease, etc. Medicaid's goal is to improve patient healthcare outcomes at an affordable cost to the patient and to society; balance cost without jeopardizing quality for optimal healthcare outcomes. We could develop a pharmaceutical case management program similar to Iowa's Medicaid Program where physicians and pharmacists work cooperatively in teams to deliver care to patients at high risk for medication-related, disease oriented problems. Protocols are developed and each care team member receives equal reimbursement for services provided to patients.

The bulk of the department's expenditures under pharmacy is for the cost of the drug product. How does the department plan to address this?

DMA is concerned about the escalating costs for prescription medications. Our drug expenditures are rising rapidly and the department must apply manageable constraints within our program. All health plans, not just Medicaid, are voicing concerns about drug spending. DTC sales campaigns along with the accelerated approvals of new, higher-price drugs, and increase in volume of prescriptions, all have compounded the burden to the prescription drug program. There has also been an increase with recipient eligibility. DMA has evaluated the possibility of obtaining the services of a PBM to incorporate a comprehensive plan for accomplishing tasks as outlined in our scope of work: voluntary preferred drug list, step therapies, prior approval list, prior authorization/help desk services, and provider and recipient training. All of the above would help decrease over-utilization of our high drug cost expenditures while improving appropriate drug usage as determined by approved, acceptable clinical guidelines (protocols), evidenced-based literature, consensus opinions, and best practice guidelines. DMA implemented a State MAC List for some generic drugs on December 1, 2001 to help control pharmacy expenditures. In addition, DMA has also incorporated a two-tier recipient co-payment structure to allow cost-sharing with our patients; $3.00 for all brand name drugs and $1.00 for all generic drugs. ❖

Medicaid and Pharmacy 2001:

"Don't Shoot The Messenger"

by Mike James

The Division of Medical Assistance (the Medicaid Division) of the North Carolina Department of Health and Human Services (HHS) once again appears to wrongly blame retail pharmacy for the tremendous increase in Medicaid prescription costs. Over the years many funding problems have surfaced in the Medicaid Division, due to the high costs of the program. Consider the following:

- Medicaid costs for prescription medication rose 19.2% in the past year. Retail pharmacy did not contribute to this increase. The price of drugs, not reimbursement fees to pharmacies, caused the increase. Reimbursement fees to pharmacies remained unchanged since 1992.
- The General Assembly and HHS seem unwilling to address the true facts about the dramatic increase in manufacturers' drug prices. They have chosen to continue to allow the burden to fall on pharmacies by reducing reimbursement compensation.
- The General Assembly and the Medicaid Division have shortsightedly identified reducing pharmacy provider reimbursement as the way to save costs in the Medicaid prescription drug program. This is a fundamental error since pharmacies do not determine the costs of prescription medication. Pharmacies are taken for granted, and consequently are easy targets.
- National statistics comparing costs over the last ten years of the average Medicaid prescription drug claim and the average dispensing fee show that retail pharmacy Medicaid reimbursement is each year a reduced percentage of the costs of prescription medicine to the Medicaid program. The North Carolina Legislature and the Medicaid Division act as though retail pharmacy is the cause of increased prices. Or perhaps they act despite knowing pharmacy is not to blame.
- A major retail pharmacy chain closed 240 pharmacies in the nation last year. Another major retail pharmacy chain announced the closing of 200 pharmacies nationwide this year, plus the closing of a distribution center in our State. In North Carolina last year, 40 pharmacies, 25 chain and 15 independent, closed. This is a tragic testimony to the effects of grossly inadequate prescription reimbursements.

Healthcare's reliance on prescription medication is increasing, with the number of prescriptions expected to double in less than ten years. North Carolina legislative leaders cannot allow a lack of fiscal fortitude to determine health care policy and access for our citizens. State agencies should employ long-term strategies that do not sacrifice accessibility or quality of service to these patients. A "band-aid fix" such as reducing already low payments to pharmacy providers is only a gimmick that places Medicaid recipients at risk to lose access to needed medicine. Addressing the real cost issue could benefit the present revenue shortfall and can help prevent the larger revenue problem, which will occur next year.

North Carolina pharmacy leaders have offered fiscal solutions to the HHS and legislative leaders for Medicaid economic recovery. These solutions could provide HHS savings of millions of dollars in a 12-month period. The Medicaid Division should take immediate action to implement these savings.

The General Assembly, HHS, and the Medicaid Division should remember: You don't shoot the messenger. You deal responsibly with the uncomfortable message.❖

About the Author...

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Fall 2002 Applications for UNC-CH External Doctor of Pharmacy Program

A SPECIAL NOTE: The External Doctor of Pharmacy Program was designed to meet the needs of practicing pharmacists, and to continue operating as long as sufficient interest remained to sustain the Program. Our original estimate was for a 10-year period of operation: 1996 – 2006. In reviewing our recent application and enrollment trends, it appears this estimate may be correct. If so, we may admit only one more class. Pharmacists who are interested in the UNC-CH External Doctor of Pharmacy Program should be aware that only one additional class may be enrolled. Applications will be available in January 2002. The application period will be from February 1 through May 1 for the Fall 2002 Semester. To request a brochure or application, please contact Cathy Hardee: phone: 800/257-3561 or 919/962-5000; fax: 919/843-9255; e-mail: cathy_hardee@unc.edu. Additional information about this Program is available at: www.pharmacy.unc.edu/pharmacy/programs/externalPD/index.html.

Pamela Joyner, EdD, MS, Associate Dean for Professional Education, UNC-CH School of Pharmacy, Beard Hall – CB #7360, Chapel Hill, NC 27599-7360

Clinical Corner

The Kroger Company

Diabetes Care in a Retail Setting

by Ouita Davis

It is not uncommon in the grocery-pharmacy setting to see the same patients and their family members several times in the same week. This allows the opportunity to learn names quickly and obtain a snapshot of their family relationships, food-buying habits, and other "non-medical" perceptions that relate to their total physical and mental health status. The Kroger Company is the largest grocery retailer, as well as the largest grocery-pharmacy retailer, in the country. Despite the operational requirements that the Kroger Company must have in place to succeed, a pharmacist does have the ability, at store level, to be entrepreneurial in spirit with regard to community involvement and patient care initiatives.

Five years ago we began to build a team of pharmacists, technicians, and support management to create a pharmacy that not only provides the basic dispensing and counseling needs of patients, but also establishes the groundwork for a specialized pharmacy that would concentrate in diabetes care. Today, our site employs three full-time pharmacists and technicians. Two of our pharmacists have 15 years of clinical experience combined, and one has recently completed Lifescan's "Pharmacy Partners in Diabetes Care" certificate program. With the assistance and support of various pharmaceutical companies, pharmacy students interested in diabetes care, and all of the employed staff and management, our site is becoming known as a pharmacy that strives to provide the best possible pharmaceutical care to patients with diabetes.

Community screenings and meter training are the two avenues that we use to attract potential and newly diagnosed patients with diabetes. A monthly advertising calendar is maintained outside the pharmacy with the dates and times of screenings for cholesterol, blood pressure and glucose. Glucose and blood pressure screenings are provided on a first come first serve basis on the scheduled date, however, we do require appointments for cholesterol screening ahead of time to help estimate the amount of testing supplies we will need. A fee is charged for all of the screenings provided and no insurance is filed. Abundant opportunities exist in this type of environment to address multiple questions related to diabetes, and detect those who are at risk for other potential problems as well. We have been screening for less than one year and have already detected two patients who have been diagnosed with Type 2 Diabetes. The first patient attended one of our screenings and had a blood glucose of over 350 with all the classic symptoms – unexplained weight loss, excessive thirst and urination, and blurred vision. She immediately made an appointment with her physician and she is now doing very well on metformin and is using her glucometer regularly. She wrote, "...I wanted to thank Kroger for starting the glucose screening program. If I had not stopped by for that painless finger stick, and symptom and risk survey, I am not sure when I would have found out that I had diabetes. Because you were there and because of the helpful...information you shared, I was able to take action and ...see my doctor right away. I was diagnosed with Type 2 diabetes and I am now taking metformin to combat it...It may very well be the best five minutes I have spent and may have saved my life." In March, a second patient was screened with glucose of 97. Within seven months he was back in the pharmacy complaining of polydypsia and polyuria. His glucose registered 160. He has since been diagnosed with Type 2 diabetes.

Screening sheets are maintained for each person who is tested. SOAP notes, as well as the screening sheets, are made available to the physician if a diagnosis is made.

Every meter bought at our pharmacy is accompanied by an offer to teach the patient or caregiver how to use it. If a person can be taught how to adequately use their glucometer, then they are well on their way to adequately controlling their glucose and delaying complications from diabetes in the future. We maintain pharmacy intervention sheets on each person we teach, and we charge a small fee for this service. Most patients agree that this service is very beneficial.

Other unique activities at our pharmacy include Diabetes Awareness Day every November, free nutrition tours, and aggressive pursuit of funding.

Too often pharmacists expect that they will get a "job" in an already established clinical site, practice at that site every day taking care of patients, and then go home with a "good feeling" about the work they have accomplished. That may be the situation in some hospital settings, but it is not yet to that standard in retail. Maintaining a high level of expertise, care, and professionalism requires patience, vision, energy, the willingness to alter the vision to fit the available resources, and the ability to sell the service to patients. The job of upper management is to provide the time for a pharmacist to see patients when appointments have been scheduled, advertising, and philosophical support. Our pharmacy has made progress toward bringing clinical pharmacy to the retail setting. Though we have a long way to go, we are excited about the future. ❖

About the Author...

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Legislation Needed to Allow Tech-Check-Tech Procedure

by Marlene Dean

I began working as a pharmacy technician in 1988 and have seen the role of pharmacists and pharmacy technicians change and expand over the years. Pharmacists have become more active clinically and have more patient contact and counseling responsibilities. With these increased demands on the pharmacist's time, the duties of pharmacy technicians have grown. Becoming certified is one way many technicians have shown their dedication and desire to develop new skills. Pharmacy technicians can and should have tasks assigned to them that can free pharmacists to invest more time in direct patient care. One way technicians could be used in the future, when legislation allows, is with a tech-check-tech procedure. This is a process that would permit specific pharmacy technicians to check the work of other technicians under certain circumstances.

For over 10 years I have worked in a community hospital pharmacy setting that serves an average of 100 patients each day. Patient medication cart fill has changed little, with the exception of going from a daily cart fill to a three-day a week schedule. With the addition of Pyxis machines to our hospital, we have been able to forego cart fill in some areas. Even with the reduction of days and departments, cart fill can be a time-consuming activity, using a great deal of pharmacist and technician hours.

Currently, we have two technicians calling out the medication list to two pharmacists who fill the patient's bins. The interruptions are frequent. Cart fill is halted and resumed many times to answer phone calls or help a nurse who has stopped by with a question. Many urgent needs must be met during this period. I would like to see a time when cart fill could be assigned primarily to technicians, allowing pharmacists to attend to medication information requests more fully.

Pharmacy technician responsibilities in many hospitals include inventory management, IV preparation, medication charging, and filling medication dispensing devices and unit dosing medications. Additional responsibilities may fall to pharmacy technicians as our profession develops. Governor Easley's signing of legislation that recognizes pharmacy technicians as an entity is a step in that direction. Studies on technician versus pharmacist accuracy have been conducted in the past, and many more will be necessary in upcoming years to determine the viability of legalizing tech-check-tech.

In our community hospital setting, with certain restrictions, tech-check-tech would be ideal for our cart fill procedure. Specific guidelines would have to be adhered to. Technicians permitted to serve as checkers would have to meet particular criteria. These technicians would have to have a combination of many years of hospital experience and certification, a proven high rate of accuracy, and be specifically trained for cart fill. They would also need to show a sense of ownership and obligation to the institution. Additional training would be needed for accountability.

Cart fill conditions that would allow for tech-check-tech must be clearly defined. All patients' medication bags would still require an initial check by a pharmacist. Technicians would only refill existing medication bags. A pharmacist would always have to be present for any questions that might arise. Also, at the end of cart fill, a pharmacist should audit an adequate percentage of the bins for accuracy. Registered nurses would perform a final check.

The reasons to strive for legislation that one day will allow for tech-check-tech are many. Increased responsibilities delegated to certified pharmacy technicians create job satisfaction and free pharmacists to spend more time with clinical and counseling matters. Using a technician where a pharmacist had been used before makes sense economically. Also, pharmacists would be able to attend to more urgent situations without delay. Technicians would be less apt to be interrupted and could devote their undivided attention to the task at hand.

Pharmacy technicians have come a long way over the years. As our career grows so will our responsibilities. I look forward to our progress, knowing that the pharmacy profession will benefit from our growth in the healthcare team. Tech-check-tech is just one way we may be able to help pharmacists better serve our patients in the future. ❖

About the Author...

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NCAP Enjoys Record Breaking Attendance a

Nearly 800 people attended NCAP's Annual Convention and Carolina Seminar October 29-31 at the Sheraton Greensboro Hotel. The three-day event included the inaugural session of the House of Delegates, NCAP's new policymaking body. Over 100 people attended a Sunday evening Leadership Dinner featuring live entertainment by the Greensboro Youth Chorus. Pictured here are highlights from the Monday night Awards Program. The next NCAP sponsored meeting will be held April 21-23 at the Sheraton Imperial Hotel in Research Triangle Park, North Carolina.

Fifty Plus Members for 2001: (l to r) William H. Barton, Olin Henderson Welsh, James C. McGee, Ritchie A. Russell, Sr., Lloyd Milton Whaley. Not pictured: William Franklin Allen, Edward Brisson , Christine Tunstall Buchanan, Joseph Washington Chandler, Robert Lindsey Dewar, James Henry Dowdy, Flora Nell Evans, James Chandler Gabriel, Ray Truman Hudson, Alton S. Parrish, Robert Russell Sampson, Gene S. Sherard, Christopher Columbus Turner, Jr., William Boling Van Valkenburgh, Waits Artemus West, William Hooper Wilson, and Howard Avant Yandle.

Bill Harris (l) received the **Bristol Myers Squibb Pharmacy Leadership Award** and the **Merck Pharmacy Leadership Award** from Ross Brickley.

(l to r) **Dan Garrett** and **Beth Williams** received the **Presidential Award** from Bill Harris.

Keith Elmore (l) presented the **NCAP President's Award** to **Bill Harris**.

Don Heaton (l) received the **Wyeth-Ayerst Bowl of Hygiea Award** from company representative Jack Molnar.

Bryan Bray (l) received the **DuPont Innovative Pharmacy Practice Award** from Keith Elmore.

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The **McKesson HBOC Leadership Award** was presented to **Ross Brickley** (l) by Frank Burton.

The **NCPA Pharmacy Leadership Award** was presented to **Ross Brickley** (l) by Whit Moose, Sr.

001 Annual Convention & Carolina Seminar !

Penny Shelton (l) received the **Pharmacists Mutual Companies Distinguished Young Pharmacist Award** from Field Representative Ron Stoll.

Rite of Roses: Vivia Creech and Lib Fearing, Co-Presidents of the NCAP Auxiliary, place roses in a vase to honor NCAP members who have died within the past year.

Steve Caiola (l) received the **Don Blanton Award** from Charles D. Blanton, Jr. (r).

Jennifer Burch (r) presented the **Ambulatory Care Pharmacist of the Year Award** to **Bill Mast** (l).

Mike List (r) presented the **Chronic Care Pharmacist of the Year Award** to **Ross Brickley** (r).

Lynne Alexander (r) presented the **Acute Care Pharmacist of the Year Award** to **Bill Harris** (l).

Continuing Excellence Award recipients: (l to r) **Craig Money, Lorie Poole, Lynne Alexander**, and **Vance Collins**. Not pictured: **Christopher Sain, LeAnne Kennedy, Jerry McKee, Regina Schomberg**, and **John Kessler**.

Alice Foust (r) presented the **Technician of the Year Award** to **Faye Elliott** (l).

Is **Pharmacy** Your **Job** or **Profession?**

In an effort to increase NCAP membership and create awareness about the organization, member Beth Williams sent the following letter, along with a membership application, to her fellow pharmacy staff employees at Wake Forest University Baptist Medical Center.

by Beth Williams

I don't know about you, but I joined this profession because I wanted to make a difference; I wanted to help people. Why did you go to pharmacy school? I'll never forget how it happened for me. I was 15 years old. It was a crisp autumn afternoon, and I was practicing my twirling routine to "Footloose" in the driveway. My neighbor, who owned a community pharmacy in downtown Hendersonville and a dress shop in the Blue Ridge Mall, stopped on his way home from work. He said he needed help at the pharmacy and his wife needed help at the dress shop, and asked if I was interested in a part-time job. I would have my driver's license in two months, and I'd always intended to get a part-time job. The timing was perfect! Mr. Baber suggested that I talk to my parents and visit each business to see which I preferred. What teenage girl wouldn't have chosen the dress shop?!

I started working at Mr. Baber's pharmacy six weeks before my 16th birthday, and by the time I turned 17, I had plans to go to UNC and become a pharmacist... because I wanted to help people. Mr. Baber is still dispensing prescriptions at Whitley Drugs, and he's still helping people. On the surface, the store looks the same, but it doesn't feel the same. Is pharmacy today the same profession it was when you became a pharmacist?

As the newcomer to the department, I don't mind saying it, and in case you didn't realize it, we are downright spoiled in this department! We have benefited from years of strong leadership and have been protected from the disease that is plaguing our profession. Have you gotten a prescription filled at a chain pharmacy lately? Our colleagues in the community setting are struggling to fill 300 prescriptions within eight hours, and prescription benefits managers dictate their workflow. Reimbursement from third parties has reached an all-time low, to the point where independent pharmacies and consultant pharmacies can't afford to keep their doors open, and a nearby hospital declined to renew their BCBS of NC contract. A Director of Pharmacy at another hospital in the state was recently forced to cut back, and had to let some pharmacists go. How do you ensure your professional viability in today's changing health care environment?

We are also fortunate that pharmacy has a unified voice in North Carolina. Up until two years ago, pharmacy was the best running joke in the state legislature. Lobbyists didn't have to work too hard to crush a pharmacy bill. We did it ourselves, and all it took was getting the community pharmacists and the hospital pharmacists in the same room. How pathetic is that! Since the unification of North Carolina's four pharmacy organizations two years ago, our profession has enjoyed a successful legislative track record. You may be asking, "Yeah, but what's in it for me?" What's in it for you is the security of your professional future. The Board of Pharmacy can't do it, and as much as we'd like to think differently, our employer can't do it. Only we have control over our professional futures, and only the state pharmacy association has the ability to represent our interests.

In light of the many successes it's enjoyed since its inception, the North Carolina Association of Pharmacists (NCAP) has reached a critical crossroads. Without the support of new members, our state professional association will not be able to operate at its current level. I personally don't accept this as an option, because quite frankly, there are too many issues looming on the horizon for us to retreat, and as Executive Director Fred Eckel has stated, "we have let others take care of us for too long." It is our turn to step up to the plate. Membership in the state pharmacy association is our professional responsibility. In addition to the legislative voice, membership benefits are numerous (biweekly e-news updates, networking opportunities, educational programming at state meetings, quarterly journal, etc.). The cost of membership dues has been raised as an issue for some, but I don't know a pharmacist today who can't afford the dues...the cost of an annual membership is $0.50 per day or less than 10% of the salary adjustment that we unexpectedly received this year.

I challenge you to be part of the solution instead of part of the problem. If you are not already a member, join NCAP today! If you have questions about the organization and where it is going, please call 919.967.2237 or check out NCAP's state-of-the-art web site at www.ncpharmacists.org.

The thought has crossed my mind on more than one occasion. What if I had gone to work at the dress shop? Do I have any regrets? Absolutely not! Because I wanted to make a difference...I wanted to help people. I just hope that in 10 years I'm not asking myself, "What if there hadn't been so much apathy in our profession...where would we be today if we had invested in NCAP? ❖

About the Author...
Beth Williams, PharmD, BCPS, is the Assistant Director of Pharmacy at Wake Forest University Baptist Medical Center. She can be reached at bewillia@wfubmc.edu

NCAP Dues Prove to Be a Real Bargain

Your 2002 NCAP membership dues are a real bargain when compared to other professional healthcare associations in the state. The comparison, at right, reflects the cost of annual membership in other associations that provide similar services to those of NCAP.

The NCAP staff would like to thank you for your support in 2002. Now is the time for you to reach out to fellow pharmacy professionals and urge them to join our association. There is power in numbers and with your help we can accomplish all of our goals for the coming year.

Annual Membership Dues for various professional organizations in North Carolina:

North Carolina Association of Pharmacists	**$175.00**
North Carolina Nurses Association	$225.00
North Carolina Physical Therapy Association (membership required in national chapter)	$350.00
North Carolina Medical Society	$398.00
North Carolina Chiropractic Association	$660.00
North Carolina Dental Society (membership required in 3 other organizations)	$850.00

Providing Primary Care Services in a Rural Community

by Stephanie Pihl

As a Community Based Practice Faculty member, I have been in Ahoskie, North Carolina since mid-1996. I began my career in Ahoskie as a Pharmacist Clinician with Ahoskie Family Physicians and soon found myself seeing primarily patients with diabetes. Although that was not my original intent, the sheer number of unmanaged patients dictated otherwise. Within a short period of time, my physician colleagues jokingly dubbed me the "Diabetes Queen." When I first began practicing in Ahoskie, the care and management of patients with diabetes was merely a career avenue for me. In late 1999, however, my career focus hit home with my own diagnosis of Type 2 Diabetes. From then on, the care of patients such as myself has become more of a crusade than a career.

Determining the Need

In small rural counties such as Hertford County, neighbors share many common experiences. Unfortunately for many in this eastern county, one such shared experience is the diagnosis of Diabetes Mellitus. By 1993, 1,282 people in Hertford County had been told that they had the disease and just as many people were thought to be affected but undiagnosed.

At the state and national levels the numbers rise to nearly 300,000 and 16 million, respectively. Though the state and national numbers seem much higher, Hertford County actually spends more money per resident to treat diabetes-related hospitalizations. Annually, the cost per resident for such hospitalizations is $130.36 in Hertford County while only $101 per resident is spent in other counties in North Carolina. Despite efforts to care for residents with diabetes, the disease still contributes to 40 deaths per year in Hertford County and 5,100 deaths across the state.

Though these figures may seem frightening, a concerted effort was begun in 1997 by area healthcare providers to reduce the impact diabetes has on the residents of Hertford County and surrounding areas. Studies such as the Diabetes Control and Complications Trial (DCCT) have proven that improved glycemic control and lifestyle modifications can reduce or even prevent many of the long-term complications of diabetes. Armed with this information and our employer's support, Debbie Klingler, RD, and myself began a Diabetes Support Group in the area. In addition to providing social support to patients with diabetes, our goal was to teach individuals the skills necessary to manage their disease for better long-term outcomes and quality of life. Although our support group represented a vast improvement in services to patients with diabetes in our area, we still lacked a truly multi-disciplinary approach.

Meeting the Need with Unique Services

By mid-2000 our employer, the local health department, was able to secure funding to establish a Diabetes Management Center. In July 2000 the Center began seeing patients with a multidisciplinary staff consisting of myself as Clinical Director/Pharmacist Clinician, a registered dietician, a registered nurse, and an office manager. Patients were seen on an appointment basis following referral from their primary physician. On the referral form, physicians had the choice of which services to refer patients to. Interestingly, greater than 80% of physicians were referring to the Center specifically for medication management.

As a Pharmacist Clinician, I would evaluate the patient's current level of glycemic control, concurrent disease states, current medications, lifestyle, and ability to afford their prescribed medications. When necessary, medication regimens were changed following written and verbal recommendations to the medical provider. Additionally, I would supply patients with a home blood glucose monitor if necessary and provide training for appropriate use. As members of a multidisciplinary team, our nurse, dietician, and myself routinely met to discuss patients and develop a plan of action for each patient.

In addition to seeing referred patients, I was available both at the Center and on a beeper after hours for physician questions and consultation when needed. Eventually, this led to two physicians from different practices asking me to see patients in their office one-half day per week.

Stumbling Blocks

Early on, it was recognized that reimbursement was unlikely to cover the costs of running the program. Although our program gained American Diabetes Association recognition in December 2000, our Medicare provider number was not approved until September 2001. Given that Medicare insured some 70% of our patient base, not being able to bill Medicare was a huge obstacle. It was imperative that we explore other funding streams. We joined forces with University Health Systems to explore alternative models to providing comprehensive diabetes care while improving reimbursement. Together, we developed a strategy for providing diabetes management services to patients within a physician's office practice. One afternoon a week, the physician's office became a diabetes clinic where my staff and I provided 45 minutes of Diabetes education followed by the provision of consultation services in conjunction with the physician. This allowed the practice to bill insurers a physician level office visit for each patient seen. The Diabetes Center, in turn, was reimbursed a flat fee covering the cost of our staff salaries.

The revenue generated from this unique project, along with a small grant, allowed the Center to continue operations until our Medicare provider number was granted.

New Directions

Recently, I had the opportunity to pursue a new challenge in another community. Last month I joined the staff of Washington County Hospital as Director of Pharmacy where I play a dual role. Not only am I responsible for the management of the pharmacy but also for the development of Pharmacist Clinical Services. I am just beginning to work with administration to initiate both an outpatient diabetes management program as well as an anticoagulation clinic. On my own, as a consultant, I continue to see patients in one local physician's office one late afternoon per week. ❖

About the Author...

Stephanie H. Pihl, PharmD, CDE, is currently Director of Pharmacy at Washington County Hospital and Clinical Assistant Professor at the UNC School of Pharmacy. She can be reached at rxcist@coastalnet.com

MEDS Program Serves Senior Needs

Briefly describe your overall practice.

MEDS or Medication Education for Drug Safety is a Resources for Seniors, Inc. (RFS) program. RFS is an agency for aging which has provided a variety of services and programs for seniors in Wake County since 1973. RFS is a private, nonprofit agency formerly known as Wake Council on Aging. Four years ago the RFS Vice President and Care Management Director, as well as the RFS social workers, recognized the need for a pharmacist's knowledge and skills. Medication problems were common among RFS clients, and social workers were constantly being bombarded with medication-related questions from clients, caregivers and family members. I joined RFS in August 1999 to develop a plan for the MEDS program and to begin initiating services for RFS clients identified as at-risk for medication-related problems.

by Penny Shelton

From September 1999 until May 2001, the MEDS Program provided comprehensive medication evaluations and patient assessments only for RFS clients. The primary source of referrals continues to come from the Community Alternative Program for Disabled and Aged (CAP/DA). These Medicaid waiver recipients in Wake County all have an RFS social worker as their case manager. RFS clients are also referred from adult day centers, senior centers, adult-housing complexes and from our Medicaid at-risk program. In May 2001, we launched our services to all seniors living in Wake County.

During the first 18 months of operation, we identified various medication-related needs for seniors in our community. This experience and information was used to develop the framework for the MEDS Program as it exists today. Currently, we have three services: our traditional comprehensive medication evaluation; medication management for non-adherent patients; and a medication assistance plan for seniors having difficulty affording medication. Today we receive referrals from patients, social workers, nurses, geriatric care managers and physicians across Wake County.

What unique services do you provide?

The actual work that we do is not unique. However, the way that we have packaged our services and the fact that we operate within an aging agency is certainly unique. Also, the majority of our service is provided directly in the home of the patient or caregiver. Seeing a patient in their home environment provides a perspective that I never realized as a retail, hospital or consultant pharmacist. Now that our program's services have become better known in the community, it is not uncommon to receive a referral for more than one service.

Once a referral is received and we determine what service(s) is being requested, we call the client and schedule an appointment. For a patient referred for our comprehensive medication evaluation, we will interview the patient and/or caregiver to obtain a medical and medication history, as well as determine their understanding of their medications and conditions. We have the patient sign a medical release form so that we can confirm information obtained in the interview and obtain laboratory results from their physician(s). We also have the patient sign a pharmacy release so that we can communicate with their community pharmacist and obtain a refill history. We conduct a thorough medication review and provide a written summary of any problems identified. This information is forwarded to the physician by fax or phone, if deemed necessary. We provide education to the patient or caregiver to help answer their questions or concerns. We also provide education to improve deficits identified during the interview regarding their medication or disease state knowledge, medication-taking and/or disease management behavior. Finally if necessary, we provide the patient or caregiver with a checklist of items to discuss with their physician.

For patients referred for medication management, we schedule a home appointment to review medications in the home and to assess the patient's knowledge and adherence. We have the patient sign our release forms and contact the physician for an up-to-date medication list. Often patients are seeing multiple providers and we have to communicate with everyone to make sure all providers have an accurate list of medications. Then we contact the pharmacy to get a medication refill history to compare with the list and with bottles in the patients home. If a discrepancy is detected we try to determine what factors are involved. Is it due to cognitive impairment, a transportation problem, financial struggles or maybe a personal health belief? Maybe it's because the patient has been homebound and not received much medication education or perhaps it's due to confusion because the regimen is very complex. Regardless of the factors involved we attempt to identify the relevant ones and then put together a plan to help with adherence. We also assess the client for various compliance aides and determine which may be most beneficial. In the end we report our findings to the person who made the referral and to the primary physician. We also discuss our findings and solutions with the patient and caregiver. One option we provide for patients is a service where we fill pillboxes or cartridges for electronic devices. This service includes calling in refills to the pharmacy and arranging for delivery or pick up in order to prepare the replacement cartridges.

Patients and families appreciate our services. In addition, our tracking of service outcomes has identified that our

program is keeping people independent and at home longer. We have also identified reduction in more costly healthcare utilization such as emergency care, hospitalization, and unscheduled physician visits.

Are you being reimbursed for services you provide?

Yes and no. We have developed a fee schedule for all of our services. Our outreach to the community is beginning to show increasing referrals each month, for which we are paid. However, internal referrals from RFS typically are for patients living in poverty. For these individuals we have a sliding scale so that even patients with very low incomes still pay a nominal fee. Fortunately, RFS was able to secure grant funds to help subsidize services provided to low-income seniors during the first three years of the program, which runs through June 2002. We are continuing to spread the word about our services and we are focusing on expanding the medication management service. We believe children of aging parents would be very receptive to paying for this type service if it meant fewer lost days of work and assurance that mom or dad's medication needs were being met. As we work to increase our private-pay customer base, we will also continue to seek grant support so we can further provide services to low-income elders.

What were/are your stumbling blocks?

Initially, our stumbling blocks were figuring out what our community needed and how to create the service so that it would meet a need but do so within our available resources. At this point, our program is providing these necessary services which have demonstrated a positive impact on the lives of those who receive these services. Today our stumbling blocks are different, but as you might imagine, they include financing, staffing and marketing needs. Currently, we do not have money for marketing to more of the community to help with sustainability. Moreover, if we were to have a successful marketing campaign, we do not currently have the staff to handle a huge influx of new clients that a widespread marketing strategy might produce.

Where are you heading now with your practice?

From an RFS perspective, we are very interested in analyzing our services and developing a business plan that may allow for duplication of our program in other county or state aging agencies. This will take a while longer to do. We've proven clinically that our services make a difference. Now we have to demonstrate that this type of program can operate cost efficiently and is therefore worthy of duplication.

In general, we have five goals for 2002; 1) obtain renewal funds from the Wake County Hospital Alliance to continue our services to the indigent and aide in expansion; 2) obtain an educational grant or contract to help with marketing, expansion or internal projects; 3) establish a collaborative practice with a local geriatrician; 4) expand our medication management service; and 5) grow our private pay referral base and enlarge our staff. ❖

Acknowledgement

I'd like to thank my staff members, who help make this a truly rewarding practice: Laura Brewer, PharmD and Denise Shehy, Program Assistant.

About the Author...

Penny Shelton, PharmD, BCPP, FASCP is the Director of the MEDS Program and Senior Care Pharmacist with Resources for Seniors, Inc. in Raleigh. She can be reached via e-mail at pennys@rfsnc.org or at www.medsprogram.com

Residency Provides Intense, Practical Experience

by Julie S. Creger

Completing a pharmacy practice residency at Mission St. Joseph's Hospital has been a key first step in my pharmacy career. Although I received exceptional training at Campbell University School of Pharmacy, I wanted to expand my knowledge base through clinical experience. The beauty of a residency is that it provides an additional year of intense practical experience under the guidance of seasoned pharmacists. I have been given ample opportunities to apply my knowledge to patients daily, making the information more memorable. One of the leading reasons that I chose to complete a pharmacy practice residency was to enhance my public speaking and teaching skills. I enjoy interacting with pharmacy students, nurses, and medical residents because of the teaching opportunities it affords and because it inspires you to "stay on your toes!" I chose Mission St. Joseph's in Asheville for my pharmacy practice residency for several reasons; 1) the pharmacists are talented, genuine and truly excited about their involvement with residents; 2) the medical staff holds pharmacists in high esteem and requests our involvement in patient care; and 3) the residency curriculum is exceptionally flexible and allows me to tailor the program to meet my particular needs and interests.

Julie Creger, PharmD, (right) and fellow resident Matthew McNeil, PharmD, at the ASHP Midyear Clinical Meeting in New Orleans, LA.

Perhaps the most exciting, yet grueling, aspect of the resident's year is the residency research project. The evolution of the residency project begins with choosing a topic. I chose a project designed to validate a correction factor for the commonly used Cockroft-Gault creatinine clearance estimate equation to be used in critically ill patients. The correction factor was developed in Phase I of the study by comparing creatinine clearance determined by a 24-hour urine creatinine concentration to the Cockroft-Gault estimate. After the topic was identified and the background research completed, I submitted a data collection tool and project proposal to the Institutional Review Board (IRB). The protocol was approved by IRB and data collection is ongoing. The results of my study will be presented at the Southeastern Residency Conference in Athens, Georgia in April, another opportunity to perfect my speaking skills. Through this process, I hope to establish a more accurate estimate of creatinine clearance for use in critically ill patients at Mission St. Joseph's. I plan to publish the information for the benefit of other institutions.

In addition to the valuable experience that I have gained at Mission St. Joseph's, I have benefited the hospital in many ways. During the year I revised the diabetic ketoacidosis protocol and educated both pharmacists and physicians about reducing our inpatient use of costly medications such as infliximab that can be safely given as an outpatient. Additionally, I review interesting patient cases or new practice guidelines once a month at the pharmacist's clinical meeting. I also provided a continuing education program highlighting recent changes in the diagnosis and treatment of hyperlipidemia. I have completed a drug utilization evaluation concerning the appropriate of use of lipid amphotericin B formulations. The results were presented during the resident's poster session at the American Society of Health-System Pharmacists Midyear Clinical Meeting in New Orleans, Louisiana last December. The findings will be used to push for more appropriate use of this incredibly expensive agent including use of inexpensive alternatives. The residents participate in weekly journal club presentations and write articles for the Pharmacy and Therapeutics Newsletter published by the Western North Carolina Regional Drug Information Center. Beyond my daily patient care responsibilities, I perform the duties of a staff pharmacist every other weekend.

I have learned so much in the past six months. I have extended my ability to effectively drive prescribing habits at my institution and to appropriately make clinical decisions based not only on evidence-based medicine but also on clinical judgement. I have developed and refined my own personal style for interacting with medical residents, physicians, pharmacy students and nurses, as well as my fellow pharmacists. My time management skills have flourished. My abilities as a public speaker have grown astronomically and I'm beginning to actually enjoy it! Through the residency experience, I have been given the opportunity to develop my clinical skills, interact with role models in the pharmaceutical care arena and grow both as a person and a pharmacist. ❖

About the Author...

Julie S. Creger, PharmD, is a Pharmacy Practice Resident at Mission St. Joseph's Health System. She can be reached via e-mail at cphjsc@msj.org

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Acute Care

"Family-like" Relationships Develop at Annie Penn

by Thomas Steve Wilson

Annie Penn Hospital (APH) is a rural 152-bed hospital located in Reidsville, in the northern piedmont region of North Carolina. Working in a small rural hospital is a lot like living in a small town, everybody knows everything about everyone. Because you spend the majority of your waking hours with this group of people, family-like relationships develop very quickly. At Annie Penn Hospital we have a name for this caring and loving attitude, its call the "Annie Spirit." In July of 2002, APH signed a letter of intent to merge with Moses Cone Health System in Greensboro, NC. It is the hopes of all of the employees of APH that this small town hospital, with its southern hospitality, will retain its character while at the same time being able to draw upon the resources of their new big brother hospital, resulting in the best of both worlds.

Being small can prove to be clinically advantageous. Because of our size we are able to clinically monitor almost every patient in our hospital, not just the "problem" patients. We have also added a clinical function to our pharmacy services that larger hospitals cannot add; our pharmacists check on every patient in ICU every day for clinical chart reviews and interventions. With two PharmDs on staff, the knowledge base is here and it was quickly recognized and accepted by the attending physicians. This was a huge step for the pharmacy's clinical acceptance among the practicing physicians. The addition of a "rounding" pharmacist position was discussed; however, since APH is attended mostly by local physicians, there is no set "rounding time," making it virtually impossible to schedule. Therefore, chart reviews are imperative for pharmacist-physician relationships to develop.

Dealing with the laboratory in a small hospital is also different. If a laboratory result is in question, the pharmacist simply goes to the lab (not call) and checks on the progress of the lab results taken. A face-to-face problem solving approach is always better than a "call to arms." In a small hospital or in a large hospital, it is imperative that you develop a good working relationship with the laboratory personnel. Your timely dosing is almost always solely dependent upon their results.

Pharmacists in smaller hospitals should make every attempt to meet, not call, every physician on every floor. You should visit every floor, every day. Determine where the physicians meet in the morning or afternoon. Find out where they eat (breakfast or lunch) and join them in a "non-professional" environment. Ask what they would like and what they expect from the pharmacy. If there are requests that you cannot fill, this is a great non-clinical environment to explain the stumbling blocks that prevent you from fulfilling their special request. Communication and honesty are the things that make relationships work. Utilize a salesman's strategy with your new physician friends and never say no, but rather "for your request to be fulfilled, the following would have to happen." Then it becomes their decision and not your refusal of their request.

Small hospitals enable physicians to quickly develop a confidence in you and your staff. The physician works best with a pharmacist he knows; as he/she becomes more comfortable and knowledgeable of the pharmacist's ability, the physician's confidence level will increase. You will know when you have reached your goal when you one day receive a telephone call from one of your physicians saying, " Can you help me with this problem?"

One of the easiest and quickest clinical pieces to add to your hospital program is having a pharmacist do discharge consultation. This takes a lot of communication with the nursing staff but remember, "floor time" for the pharmacist is very, very important time. One-on-one communication is what hospital pharmacy is all about. Taking care and communicating with both external and internal (nurse & physicians) customers makes a pharmacy successful.

Going to every floor every day will also help you get to know the nursing staff. Ever heard the expression, "The sergeants run the war?" Well it's true. Find out what is frustrating the nursing staff with regards to medication and what they expect and would like to see happen from the pharmacy. One nursing problem at APH was with their TNA administrations. TNA's were being dispensed in 1000ml units only with lipids separately. The nursing staff was therefore required to hang three bags each day, plus the patient's lipid requirement. This problem was handled simply through our P&T committee. It was requested that we change our dispensing package to a 24-hour volume bag that would also contain any needed lipids. Now our nursing staff only hangs one TNA bag every 24 hours and our start time is 2:00 pm. The physicians have also been educated to understand that a TNA start is not an emergency and will begin at 2:00 pm each day. To accommodate those who still insist on a pm TNA start bag, the pharmacy provides a "pre mix" TNA standard mixture from Baxter.

Our Specialty Clinic once had an obvious confidence problem with the pharmacy. The same orders were being faxed twice and called once or twice to make sure they had been received. Our pharmacists were spending their time matching and verifying faxed orders and call-in orders against written orders. The solution was simple. Have a "meeting of the minds" to include the Specialty Clinic Department Head, the attending physician, the pharmacy director, the chemo staff pharmacist and the chemo staff nurse. The pharmacy simply asked the Specialty Clinic nurses to select which method of transmission would suit them better. Just meeting with everyone face to face was the first big step toward building the confidence level that was needed. A good pharmacist/nurse relationship is essential for good patient care. This is accentuated in a small hospital setting. Remember, as a hospital pharmacist one of your functions is to help the nursing staff provide quality care.

One real problem in a small rural hospital that primarily serves the acute patient is the hours of pharmacy operations. Volume usually does not permit staffing the pharmacy on a 24-hour basis. We have addressed this problem with several different approaches. First, our automated dispensing system (Diebold) will allow the nursing staff access to medications at each station. If, however, the medication is not in their Diebold, the night nursing supervisor is contacted to acquire the needed medication either from another floor's Diebold or to enter the pharmacy after hours. The night nurse supervisor may obtain only non-control pharmaceuticals directly from the pharmacy. We make every attempt to keep the "night pharmacy entries" down to a minimum by varying the Diebold's stock, but after-hours entries still do occur. The drugs

obtained are monitored on a daily basis and if any are stocked in a Diebold on any floor, the night nursing supervisor is contacted the following morning. It should also be noted that a high percentage of our medication occurrences take place when there is no pharmacy intervention.

Another solution to this problem is to form an alliance with a neighboring hospital and alternate weeks or months with a second shift pharmacist. Realigning pharmacist schedules in order to extend hours is a partial solution to the absence of a second shift in the pharmacy, but before this can be done you must first be aware of your work distribution levels; robbing Peter to pay Paul will not solve any problem. In making any pharmacy decisions, you have to first consider service. The pharmacy must always provide patients, physicians, and nurses with the best patient care service possible.

There is simply no question that solving "the absence of a second shift" problem is the most resounding problem in the small rural acute care hospital. Most small hospitals can be run without a pharmacy third shift, but the absence of a pharmacy second shift in a community hospital figures as one of the impossible missions of hospital life. In a small community hospital, most of the practicing physicians have local offices and therefore make their rounds "after" their office closes at 5:30 or 6:00 pm. They usually begin their rounds around 7:00 pm, just when the pharmacy is trying to close. I am of the opinion that attempting to provide pharmaceutical care without a second pharmacy shift is like trying to put that square peg in the round hole. It can be done but it must be forced. At APH we try to maintain our strong communication lines with the physician so that he or she will feel comfortable contacting us through our "on call" devices without hesitation. This is a good cure for the symptom, but not for the disease.

Practicing pharmacy in a small town hospital can have big advantages. Pharmacists spend long hours in classrooms and on hospital floors learning how to do clinical work and do it well. We do not want to spend the remainder of our professional careers looking at a computer screen. Practicing pharmacy in a small rural hospital allows you more interactions with the patients and the physicians. Simply put, it allows you to be the clinician that you want to be, not a glorified clerk. Practicing pharmacy in a small town hospital allows you to "practice" hospital pharmacy, not just work in one. ❖

About the Author...

Thomas Steve Wilson, PD, MBA, MHA, is the Pharmacy Director at Annie Penn Hospital Campus, Moses Cone Health Systems in Reidsville, NC. He can be reached at 336.634.1010 x659.

North Carolina Pharmacist Recovery Network 2001 Annual Report

The North Carolina Pharmacist Recovery Network's caseload continues to grow. At year's end there were a total of 70 active cases. The total number of cases addressed to date is 127 with 120 cases being put under a five-year NCPRN monitoring contract, 20 of which came in 2001. In 2001, 65 of the 70 active clients remained drug free (93% for the year 2001), four of the five relapses were successfully retreated, with one choosing to leave the practice of pharmacy. Success rate as defined by total abstinence with no episodes of relapse for all clients signed to an NCPRN monitoring contract after 1995 is 81% (97 out of 120).

Referral sources for the 20 new cases in 2001 were as follows: nine cases were from colleagues, seven cases were self referred, three cases came from an employer sponsored employee assistance program (EAP), three cases came from sources described as "other," and two cases came from the Board of Pharmacy. The breakdown of all active cases by gender consists of 56 males and 14 females. For the year 2001, 15 new cases were males, and five were females. The breakdown by practice site for new cases in 2001 was as follows: 12 from chain retail, three from independent retail, two from hospital, one from long-term care, and two described as other.

In 2001, the executive director was invited to make 32 presentations on topics ranging from addiction and impairment to pain management and drug testing. Twenty of the presentations were local programs across the state of North Carolina, including the North Carolina Association of Pharmacists Annual Winter Meeting. Twelve of the presentations were out-of-state programs, including both the American Pharmaceutical Association's and the National Association of Chain Drugs Stores' Annual Meetings.

This past year has also seen a continuation in the use of the NCPRN office as a preceptor site for the UNC and Campbell Schools of Pharmacy, as well as students from Auburn and Temple University Schools of Pharmacy. NCPRN has been asked to continue to provide regular one-on-one educational instruction to first and second-year residents of the Wake Forest School of Medicine Family Practice Resident Program.

Financially, 2001 was our strongest year yet. We realized 120% of our budgeted income, and had expenses come in at 108% of budget for a net income of $30,350. Total assets and liabilities as of 12/31/01 was $74,600. NCPRN would like to thank the many corporate and individual donors who made this year such a financial success.

Other activities that occurred during the fiscal year that were directly related to the program included:

- The development of the "PRN Journal" which is written and mailed bi-annually to approximately 9,200 pharmacists and 800 substance abuse counselors.
- Sponsored NCPRN's 8th Annual Seminar on Chemical Dependency , which had 200 attendees.
- Agendas prepared and staffing for four NCPRN Board of Directors meetings.
- Quarterly client reports mailed to the Board of Pharmacy members and staff.
- Successful amendment to the Technician Bill (SB-446) to allow for technician access to NCPRN.
- Served as faculty to the University of Utah School on Alcoholism and Other Drug Dependencies.
- Representation on the NC Consortium of Professionals Recovery Programs.

Plans for the year 2002 include increasing publicity for the program. As noted in the statistics above, we need to do more to get the word out to hospital pharmacists as well as female pharmacists in all settings that help is available. The executive director hopes to visit with the directors of a number of hospital pharmacies in the 2002.

The executive director wishes to once again express his thanks to the members and staff of the North Carolina Board of Pharmacy, the members of the NCPRN Board of Directors, the North Carolina Association of Pharmacists, Campbell University School of Pharmacy, UNC School of Pharmacy, and the many pharmacist volunteers for their cooperation, without which, the NCPRN program would not be possible.

Respectfully submitted,
Dave Marley, PharmD., RAS
Executive Director

Nominations Sought for NCAP Elections and Awards

Awards

Deadline for Nominations is May 1, 2002.

It is a privilege for the North Carolina Association of Pharmacists to recognize excellence within the profession. NCAP will hold its Awards Ceremony during the Convention October 9-11 in Greensboro, NC. The Board of Directors invites NCAP members to make nominations for the following awards. Nominations must include biographical data on the nominee for review by the Awards Committee. Submit to Awards Committee, NCAP, 109 Church Street, Chapel Hill, NC 27516 (Telephone 800-852-7343; FAX 919-968-9430 or email linda@ncpharmacists.org).

Don Blanton Award: Presented to the pharmacist who has contributed most to the advancement of pharmacy in North Carolina during the past year. This award was established by Charles Blanton in memory of his father, Don Blanton, who served the North Carolina Pharmaceutical Association as President 1957-58.

DuPont Innovative Pharmacy Practice Award: Presented to a pharmacist practicing in North Carolina who has demonstrated Innovative Pharmacy Practice resulting in improved patient care.

Pharmacists Mutual Distinguished Young Pharmacist Award: Criteria for this award are: (1) Entry degree in pharmacy received less than 10 years ago (1992 or later graduation date); (2) Licensed to practice pharmacy in NC; (3) Actively practices retail, institutional, managed care or consulting pharmacy; (4) Participates in national pharmacy associations, professional programs, state association activities and/or community service.

Wyeth-Ayerst Bowl of Hygeia Award: Criteria for this award are: (1) Licensed to practice pharmacy in NC; (2) Has not previously received the Award; (3) Is not currently serving nor has he/she served within the immediate past two years on its awards committee or as an officer of the Association in other than an ex officio capacity; (4) Has compiled an outstanding record of community service, which, apart from his/her specific identification as a pharmacist, reflects well on the profession.

Pharmacist/Technician of the Year: Each Practice Forum will honor a Pharmacist/Technician of the Year. Criteria are: (1) Service to the profession, (2) Contributions to pharmacy programs; (3) Cooperation with the entire healthcare team and (4) Service to the community. Members of the Practice Forum may submit nominations for these awards. Nominations must include biographical data on the nominee.

Acute Care: Submit nominations to Lynne Alexander, Chair of the Acute Care Nominations Committee (FAX 919-681-3895 or e-mail to alexa014@mc.duke.edu).

Ambulatory Care: Submit nominations to Laura Brewer, Chair, Ambulatory Care Practice Forum (lbrewer724@msn.com).

Technician: Submit nominations to Sandi Smith, Chair, Nominations Committee (e-mail to sandra.smith@onslowmemorial.org).

Elections

Deadline for Nominations is May 1, 2002.

NCAP: During the summer NCAP will elect a 2003 President-Elect (to serve as President in 2004), a Treasurer (three-year term) and one At-large Board member (3-year term). Members may submit nominations or requests to be considered for these positions. Send to NCAP Nominations Committee, 109 Church Street, Chapel Hill, NC 27516 (FAX 919-968-9430 or e-mail to linda@ncpharmacists.org).

Acute Care Practice Forum: The Practice Forum will elect a Chair-Elect (3-year term), three Executive Committee members (3-year terms) and one Delegate to ASHP (3-year term). Members of the Practice Forum may submit their nominations to Lynne Alexander, Chair of the Acute Care Nominations Committee (FAX 919-681-3895 or e-mail to alexa014@mc.duke.edu).

Ambulatory Care Practice Forum: The Practice Forum will elect a Chair-Elect (3-year term) and one Executive Committee member (1-year term). Members of the Practice Forum may submit their nominations to Laura Brewer, Chair of the Ambulatory Care Practice Forum (lbrewer724@msn.com).

Technician Practice Forum: The Practice Forum will elect a Chair-Elect (3-year term). Members of the Practice Forum may submit their nominations to Sandi Smith, Chair, Nominations Committee (e-mail to sandra.smith@onslowmemorial.org).

Continuing Excellence Program

Deadline for applications is August 1, 2002.

The purpose of the Continuing Excellence Program is to recognize individuals who have distinguished themselves through sustained service to the profession and the public and to promote an awareness of NCAP and the profession of Pharmacy among the public and other health professions. Program Criteria and application form are available on the NCAP website (www.ncpharmacists.org) or you may contact Linda Goswick at NCAP (Tel. 800-852-7343; FAX 919-968-9430 e-mail linda@ncpharmacists.org). Award recipients will be recognized at the October Convention in Greensboro.

Small Doses

CU Students Donate to Relief Fund

C.U. Pharmacy Student Executive Board Officers present a check to the American Red Cross. (l to r) Treasurer Martie Firebaugh, president Chad Riggs, Ann Creech of the Red Cross, secretary Tracey Truesdale and vice-president Laura Williford.

During the week of September 17, Campbell pharmacy students and organizations accepted contributions totaling $4,000 for the American Red Cross Disaster Relief Fund. Hundreds of students along with the Pharmacy Student Executive Board contributed to these funds. The International Society of Pharmaceutical Engineering added $2,000 to this effort bringing the total amount donated from Campbell's Pharmacy programs to $6,000. The students submitted these funds through the Progress Energy Foundation (CP&L) matching program to provide a total contribution of $12,000. A representative from the Red Cross accepted the donation during a public ceremony at the school on October 5, 2001.

News From Pharmacists Mutual

Pharmacists Mutual Insurance Company is pleased to announce a new life insurance benefit now available with Pharmacists Mutual's Individual Pharmacist Professional Liability Policy. Policyholders under age 30 will receive, at no extra cost, a $5,000 level term-to-age-30 life policy issued by The Pharmacists Life Insurance Company, a subsidiary of Pharmacists Mutual. Current individual professional liability policyholders under age 30 will receive the life insurance benefit on their next Pharmacist Professional Liability Policy renewal dates. The term life policy will expire on the anniversary date (issue date) following the insured's 30th birthday if not converted to a whole life policy with Pharmacists Life.
The term life policy will be issued without medical underwriting. The policyholder will be able to convert the $5,000 policy to an amount up to $25,000 of whole life insurance without underwriting if done prior to the expiration of the term policy. Conversion can be made to any Pharmacists Life whole life insurance plan being offered at time of conversion.

For more information about the new life insurance benefit and the availability in your state, please call Pharmacists Mutual at 800-247-5930, ext. 711 or visit our web site: www.phmic.com (this is not a claims reporting site).

Drug Topics Pharmacist of the Year

Drug Topics magazine has named Gina Upchurch North Carolina's 2001 Pharmacist of the Year. Readers were asked to nominate pharmacists whose innovative practice made a difference in patients' lives. Gina is the Executive Director of Senior PHARM*Assist* in Durham, a community-based, nonprofit program that helps seniors with limited income obtain medication, improve health literacy, and connect with community resources including meals and transportation.

Glisson Receives ACA Award

The American College of Apothecaries presented the 2001 Albert E. Rosica, Jr. Memorial Award to Gary R. Glisson of Nashville, NC at the College's Annual Conference in October. The award, established in memory of Albert E. Rosica, Jr., a Past President of the ACA, is presented in recognition of outstanding contributions to pharmacy education. Gary is the CEO and President of Ward Drug Company.

UNC Students Attend ASHP Midyear

(l to r) PY4 students Mona Shah, Tina Bhavsar, Elaine Chin, and Christie Hughes attend Dinner with the Dean.

The UNC School of Pharmacy took 105 students to the ASHP Midyear Clinical Meeting in New Orleans, LA. Twelve students presented research posters and PY4 students Julie Cooper and Kristen Bova Campbell represented UNC in the National Clinical Skills Competition. Dean Bill Campbell hosted the whole gang for dinner on Sunday night at The Hardrock Cafe, where George Abercrombie (UNC '78 and current President and CEO of Hoffmann-La Roche, North America) also visited with students.

Medicap Opens New Pharmacies

Gaye Moseman, RPh, and her husband Bob, recently opened a new Medicap Pharmacy in Wilmington, NC. Gaye is the former pharmacy manager at the Hannaford store, located right across the street from her new pharmacy. The 2000 square foot store has a drive-thru window and a compounding consultation room.

Bobbie Barbrey, RPh, CCN, opened a new Medicap Pharmacy November 16, 2001 in Raleigh. His store features a compounding lab, consultation room, and a large selection of natural products. During Grand Opening Week, Bobbie had two representatives from two different natural product companies on hand to answer patients' questions.

Auxiliary Raffle Winners

The NCAP Auxiliary held a fund-raising raffle during the Annual Convention in October and raised over $3,000. The drawing was held the last day of the Convention and the winners are as follows:

$500.00 Cash, Olin Welsh
13" Color TV, Richard Cooper
Digital Camera, Jerry Davis
Charles Smith Print, Barbara James
Ruby Creech Watercolor, Kathryn Thutt
Jerry Miller Painting, Charlie Jones
Jerry Miller Painting, Nancy Johnson
5" Color TV, Betty Jane Upchurch
Luggage, Frances Jones
Wreath, Patty Garst
Madame Alexander Doll- Bridal, Grover Creech
UNC Basket, Rose Boyd
UNC Basket, Chris Barrick
Madame Alexander Doll- Clown, Lynne Alexander
Prayer Quilt, Betty Overman
Prayer Pillow, Warren Coltrane
Soup Mix, Randy Shafer
Soup Mix, Tonya Welch
Soup Mix, Donald Black
Angel, Gary Glisson
Silent Auction of UNC Autographed Football, Mickey Watts

Calendar

March 16: ***NC Association of Pharmacy Technicians CE Seminar,*** Pitt County Memorial Hospital. For more information call 252.861.8214.

April 5-6: ***Carolina Regional Conference for Consultant Pharmacists,*** Charlotte, NC. For more information call 800.821.4631.

April 21-23: ***NCAP Annual Spring Meeting (formerly Annual Winter Meeting)*** Sheraton Imperial, RTP, NC. For more information call 919.967.2237 ext. 22 or visit the NCAP website at www.ncpharmacists.org

North Carolina Pharmacist

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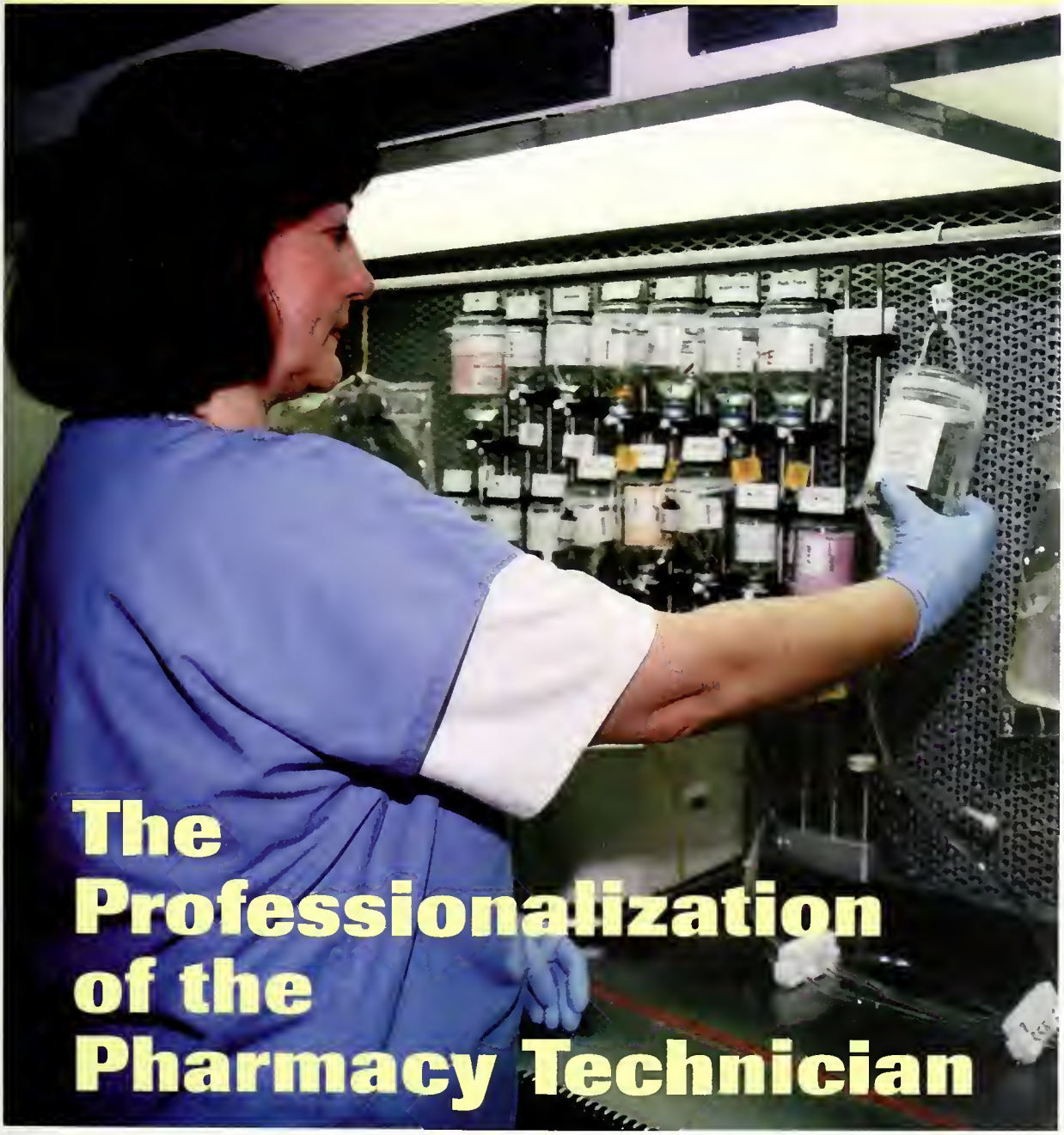

The Professionalization of the Pharmacy Technician

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North Carolina Pharmacist

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On the Cover...

Ana Dates, CPhT, works in the Department of Pharmacy at UNC Hospitals in Chapel Hill.

Cover Photo by George Rideout

Inside

Fred Eckel
Executive Director

The Professionalization of the Pharmacy Technician

Sometimes it takes a crisis to get the attention needed to consider change. We seem to have that situation in pharmacy today. The pharmacist manpower imbalance is real. More pharmacists are needed in the community setting than are available to practice there. As prescription use continues to grow this need will remain. Although new schools of pharmacy are starting, and current schools are increasing class size, these numbers will not be enough to meet the rising demand. Many new graduates go into community pharmacy but, most want to practice pharmacy like they have been taught, with time to talk with patients. Some graduates seek positions in other practice settings because these opportunities are also inviting and growing. The growth in pharmacy residencies, including community pharmacy residencies, is occurring also, further increasing the opportunities for pharmacists who complete residency training. Hopefully, pharmacists who complete community pharmacy residencies will become the change agents we need to transform community pharmacy practice.

But the prescriptions still need to be filled. Perhaps in some settings the solution will be robotics, but in most settings the transformation of community pharmacy will occur because pharmacy technicians play an important role in the prescription filling process. That means that technicians need to be better trained, but this can occur much quicker than trying to produce more pharmacists. It will also mean that trained technicians will need to be paid better, but this will be less than what pharmacists make. It may also mean that the Board of Pharmacy rules will need to be changed in order to accommodate an enhanced role for the pharmacy technician. There are certainly some circumstances where it would be appropriate for a pharmacy technician to check another technician's work.

The crisis in pharmacy practice today makes the acceptance of an expanded pharmacy technician's role easier. Yes, some pharmacists are still fearful that they could be replaced by a technician, but those numbers are certainly getting smaller. As one pharmacy technician educator said in a recent meeting, "If a technician can take a pharmacist's job then that pharmacist is nothing more than a glorified technician anyway."

What needs to happen now, I believe, is to see the pharmacy technician's role strengthened which means we have to PROFESSIONALIZE THE PHARMACY TECHNICIAN. Perhaps the recently passed Pharmacy Technician Bill will begin that process in North Carolina. The registering of pharmacy technicians with the Board of Pharmacy increases the stature of the pharmacy technician. As more pharmacy technicians become certified, their image will be further enhanced. As pharmacy managers pay certified technicians more, their value will be recognized and more young people may seek this activity as a career option. Then these better trained pharmacy technicians will be able to accept a growing role in the prescription dispensing process and the pharmacist can spend time with patients.

NCAP is committed to the professionalization of the pharmacy technician. From the beginning, we wanted pharmacy technicians to have a home at NCAP so we have a Technician Practice Forum. The Practice Forum is still a small part of our total membership, but growing. Pharmacists can help this professionalization process by encouraging their technicians to join NCAP. We are part of the same team; both committed to helping patients. NCAP has been offering review programs for technicians preparing to take the PTCB exam. We plan to continue offering these programs across North Carolina. When we offer the program this summer (see pages 22 & 23 for details) pharmacy managers will be able to send their newly hired technicians to this program to meet the Board of Pharmacy requirement for training of new technicians. Finally, we will continue to offer programs for pharmacy technicians at our educational meetings. Yes, maybe in a few years we can look back at the year 2000 and say that one of the benefits of forming NCAP was that we began the professionalization of pharmacy technicians.

Paraphrasing Winston Churchill, "the passage of the Pharmacy Technician Bill is not the end, nor is it the beginning, but it is the end of the beginning." The professionalization of the pharmacy technician may be an important cog in our efforts to advance the practice of pharmacy in North Carolina for the benefit of all citizens.

North Carolina Association of Pharmacists
109 Church Street
Chapel Hill, NC 27516
phone 919 967 2237 • fax 919 968 9430

Ross Brickley
President

Dear Members,

The increasing need for the pharmacist to be involved in the provision of pharmaceutical care has led to expanded roles for technicians in pharmacy. Pharmacists depend on them to facilitate expansion of the profession's scope of practice. Most pharmacists agree with the previous statements about pharmacy technicians, although many may have questions about how the profession should nurture the development of this component of the pharmacy work force. Pharmacists have used various types of supportive personnel in their practices for decades; the occupation of "pharmacy technician" is still in the process of becoming defined consistently throughout pharmacy. Progress is being made in reaching consensus on questions such as the knowledge, skills, and abilities required of technicians; functions of technicians; training requirements; appropriate level of supervision; and recognition by regulatory bodies.

Over two years ago, the Legal and Public Affairs Council of NCAP was assigned the charge of creating a Technician Task Force to establish formal dialogue regarding the role of pharmacy technicians in North Carolina. After several meetings with pharmacy leaders throughout the state, consensus was established and eventually legislation passed by the N.C. General Assembly requiring the registration of pharmacy technicians. The legislation provides: (1) A way to track and discipline pharmacy technicians (2) Guidelines on minimum training requirements for pharmacy technicians and (3) Expansion of the 2:1 technician to pharmacist ratio provided the additional technicians have passed a nationally recognized pharmacy technician certification board exam and the Board of Pharmacy has provided written approval.

Pharmacists are faced with declining gross margins as the cost of purchasing the medication increases; overhead and salary expenses rise; and third-party payor sources continue to attempt to lower dispensing fees to contain costs. NCAP has positioned itself as a staunch advocate for "fair" reimbursement for pharmacists in North Carolina. Pharmacists want to practice their profession in a way that permits them to take personal responsibility for improving a patient's quality of life from medication-related care. The profession is in the process, on many fronts, of re-engineering practice along the lines of pharmaceutical care. The reimbursement methodologies for the re-engineered practice models are complex as we incrementally move toward a new system of reimbursement.

A key element in pharmacy's strategy for achieving pharmaceutical care is for the pharmacist to delegate routine functions to well-qualified, appropriately supervised pharmacy technicians. This will help permit pharmacists to free up time to focus on the medication-related problems of the patients we serve. Pharmacy managers will be led to reassess how traditional pharmaceutical services are provided. Although national pharmacy organizations are leading the charge for a "new reimbursement methodology" for providing pharmaceutical care, there are demonstration projects at the State level that can re-define how pharmacists are reimbursed. NCAP has taken a leadership role in preserving reimbursement under the current dispensing fee reimbursement method of pharmacy and at the same time is supporting demonstration projects to recognize and reimburse pharmacists for the "pharmaceutical care" that we provide.

Sincerely,
Ross Brickley, RPh, MBA, CGP

...applying drug knowledge to improve health

The Future of Skilled Technicians

Technical support means different things to different professionals but to many busy pharmacists, technical support is a vital part of their daily operations. With the shortage of pharmacists expected to increase, a trusted support staff will become even more important in the future. New laws in North Carolina are allowing board certified technicians to assume greater responsibility under the supervision of a licensed pharmacist. Ultimately, a well-trained technician will enhance the role of the pharmacist, allowing them to attend to other professional duties such as patient counseling and drug therapy management.

Last year the North Carolina General Assembly passed the Pharmacy Technician Bill requiring technicians to register with the Board of Pharmacy beginning January 1, 2002. The law states that technicians already working in that capacity can register until July 1, 2002 without further education or training. Technicians who become registered after July 1, 2002 must complete a training program that includes pharmacy terminology, pharmacy calculations, dispensing systems and labeling requirements, pharmacy laws and regulations, record keeping and documents, and the proper handling and storage of medication. The ratio of technicians to pharmacists remains 2:1 but additional technicians may be added if they are certified.

Since 1994, the Pharmacy Technician Certification Board has issued certification to over 100,000 technicians in the United States and that number continues to grow. Because the role of technicians is rapidly changing, *North Carolina Pharmacist* posed the following questions to a variety of pharmacy professionals whose operations are being directly affected by these changes.

David Work, Executive Director, North Carolina Board of Pharmacy

Why is the Board of Pharmacy interested in registering pharmacy technicians?

The Board believes it is in the public interest to register technicians for two primary reasons; to detect competency issues and to be able to track people who have a history of drug diversion. Examples include a case over ten years ago at a Charlotte hospital where a tech mislabeled IV bags to be used in surgery and two patients died. In another case in Raleigh a tech compounded a prescription for Cafergot suppositories and overdosed the patient with 25 mg of atropine instead of 25 mcg and the patient barely survived. Last summer several technicians diverted controlled substances from a pharmacy in Elkin which were distributed to high school students.

How will the public/profession benefit from the new law governing the training and registration of pharmacy technicians?

The public can be reassured that all pharmacy personnel will be well trained for patient safety and registration will increase the value as well as the status of technicians.

Andrea Carter, CPhT, of Medicap Pharmacy on Harden Street in Burlington, NC.

Why do you think this new law is necessary and appropriate?

Pharmaceuticals are more powerful today and this law appropriately provides for training of personnel handling these products to meet the needs of patients.

What do you see as the future role of pharmacy technicians?

I believe that technicians will grow in their role of assembling prescriptions for final checking by a pharmacist and branch out into other more specialized areas such as compounding, claims processing and inventory control. This will improve their value to employers as well as their contribution to patient care.

George Veltri, Pharmacy Services Manager SouthEast Group, Eckerd Corp.

How will the new law governing the training and registration of pharmacy technicians impact your operations?

I do not feel it will impact the operation of the stores at all. We already have a successful and well-established training program. If anything, it will enhance our current program by ensuring our technician registration is up to date, as there is now added accountability throughout all pharmacies in the state.

How will the public/profession benefit from the new law governing the training and registration of pharmacy technicians?

Today there are problems with technicians breaking the law and moving from company to company. The new law will ensure that these technicians are "tracked." Ideally, the law will also allow a better-trained staff to perform repetitive tasks such as prescription data entry and

preparation at a high level of efficiency to allow the pharmacist more time for supervision and customer/patient interaction.

Why do you think this new law is necessary and appropriate?

The law governing the training and registration of pharmacy technicians is appropriate for the long-term health of the profession, allowing our pharmacists to meet the needs that our growing population demands. When our technicians are properly trained, our pharmacists have more time to counsel and properly advise our patients on the proper use of their medications.

What do you see as the future role of pharmacy technicians?

The future role of a pharmacy technician will grow even more. I see them being the pharmacist's right and left arm. As the volume of prescriptions continues to increase we need to free the pharmacist in order to provide counseling and information to other health care agents and our patients. Technicians in the future will need to be used as the "total" prescription preparation person. They will need to be able to efficiently handle all prescription processing, allowing the pharmacist to only focus on final product checking and patient interaction.

Ellon Barlow, Fayetteville Community College, Pharmacy Tech Program Instructor

What effect will this legislation have on recruiting technicians into your program?

Anything that validates the role of the pharmacy technician will have a positive impact on the recruitment of students into our program. One of the major obstacles to recruitment in prior years has been the lack of mandatory requirements for education, training, and certification. Hopefully, this will be the first step toward:
1) requiring training **before** taking the national certification examination and
2) being certified as a requirement of employment as a pharmacy technician

How will the public/profession benefit from the new law governing the training and registration of pharmacy technicians?

The registration offers a mechanism for the Board of Pharmacy to record the employment site of practicing technicians. This will benefit the profession by allowing employers to contact the Board about the employment history of a potential employee. This speaks to accountability of technicians for their actions. Knowing that their employment record is available to potential employers will encourage them to have an exemplary employment record. The public will benefit, perhaps only indirectly, by the process. Even though the registration is not presently tied to certification, the public will see the registration as a positive step towards requiring certain competencies in the technician. There will be a new level of security on the part of pharmacists and the public now that technicians are registered with the Board.

Why do you think this new law is necessary and appropriate?

The new law is necessary as a first step in recognizing technicians as integral and vital members of the health care team. By virtue of the registration, technicians will be held accountable for their actions. The next steps in the recognition process will be specific requirements for training and education and, finally, certification. Technicians are eager to be recognized for their knowledge and skills. The more accepted the recognition is, the more value the technician will have. With the cooperative effort of the NABP & PTCB now in place, this recognition will become a reality.

What do you see as the future role of pharmacy technicians?

Pharmacy technicians have come a long way from being an "assistant" or "clerk" who happens to work in the pharmacy area. Today they are respected members of the health care team in both the retail and hospital environments. Use

Robin Gerringer, CPhT, of Medicap Pharmacy in Burlington, NC, performs blood glucose screening.

Ruthann Duclau, CPhT, of CVS Pharmacy in Chapel Hill, NC records OTC vendor sales.

of competent technicians allows pharmacists to better serve patients because they can rely on the technician to complete the technical and clerical aspects of the medication delivery process. With the shortage of pharmacists, technicians are making very positive contributions to retention of pharmacy staff and the quality of work life. Today's public wants to know that anyone involved in the preparing and dispensing of medications has been properly and adequately educated and trained. The future role of pharmacy technicians will include more involvement in the patient care process. From an educator's point of view, that role should include well-defined areas of education which include math, pharmacology, medication record maintenance, inventory control, and dispensing functions. While some have questioned the necessity of the depth of community college pharmacy technician programs, the fact remains that the more knowledge the technician has of his role and responsibilities, the better he will perform on the job. This will, in turn, enhance patient care which is the ultimate goal of all health professionals. As I see it, there is no turning back – the role of the technician will include more, not less, responsibilities. It is up to us, as pharmacists, to ensure that they have the proper education and training to assume these responsibilities.

Stephen Eckel, Assistant Director of Pharmacy, UNC Hospitals

How will the new law governing the training and registration of pharmacy technicians impact your operations?

The new law should have minimal impact on the practice of pharmacy at the University of North Carolina Hospitals. Our present requirements for employment mandates that a technician has at least one year of work experience, a semester of pharmacy school experience, or has graduated from an accredited pharmacy technician training program. Therefore, our hope is that almost every technician that UNC Hospitals hires will already be licensed with the state (previous job), a student (does not need to be licensed), or has just completed a training program that meets the intent of the law. There will be a few individuals we hire that will be from out of the state or country, so we will need to be able to provide some basic training.

How will the public/profession benefit from the new law governing the training and registration of pharmacy technicians?

One of the immediate benefits of the new law should be increased protection of the public welfare. Ideally, UNC Hospitals will be able to hire a technician that we know has been trained appropriately. Even though the hospital practice setting is different than the community setting (unit dose, automation technology, sterile product preparation), UNC Hospitals is hiring an individual who understands basic activities like pharmacy terminology, pharmacy calculations, and pharmacy law. UNC Hospitals is equipped to provide job-specific training in aseptic technique, Pyxis® management, re-packaging of product, and computer-order entry, however, it is more difficult for us to educate the individual on basic pharmaceutical information.

For the profession as a whole, technician registration and education standards will bring consistency across work environments. No more will a work place be able to hire an individual who is not qualified and ask them to fulfill technician functions. This will be the biggest benefit to the public. No matter where patients receive their medications, they can be confident that the individual who is filling the prescription bottle is trained and competent. Also, the number of filling errors given to a pharmacist to check should be reduced. Therefore, the chance of the wrong drug getting to the patient is minimized.

Why do you think this new law is necessary and appropriate?

This new law is necessary because our profession has not consistently trained technicians in understanding medications and the distribution of them. Many people have viewed the technician job responsibility as something that is easy to learn. In a busy pharmacy that is understaffed, people (cashiers) will get recruited to function in areas outside of their job responsibility. There is no time to ask a pharmacist questions, nor is there a chance to be closely watched. Requiring a standard training before a technician is registered will help maintain our status within the community as a respected profession.

What do you see as the future role of pharmacy technicians?

I think certified technicians will continue to play a larger role in assisting in the drug distribution process. Ideally, I would like to see more pharmacy technicians viewing their job as a profession. One of the biggest challenges I have is retention of excellent technicians. Those who are highly trained will use a position in the central pharmacy as a springboard to other activities (pharmaceutical industry, specialized technician positions, or another job). By delegating larger responsibilities to a certified technician, their status within the profession and community would increase. Not only will this benefit the pharmacy technicians, but it will also definitely aid the pharmacist. They are now potentially available to focus more on the patient and less on the product.

Dot Cowan, CPhT, Chair, NCAP Technician Practice Forum

What effect will this new legislation have on technicians currently employed?

The Pharmacy Technician Bill is something that I believe all of us have been waiting for. Many of us have taken on the role of pharmacy technician as a profession and now, to be finally recognized, makes us proud. The possibility of an increase in the ratio of pharmacists to technicians can help bring some relief to the overworked pharmacists. It should give more reason for the employers to encourage technicians to become certified.

How will the public/ profession benefit from the new law governing the training and registration of pharmacy technicians?

For many years pharmacy technicians have been functioning as they are today, as a vital part of the health care team. The new laws governing the training and registration of pharmacy technicians will make us strive to be even better than we have been in the past. With some standards set in the training requirements, technicians will be better prepared to help meet their part of the health care challenge. This should give the public a better qualified technician to do the job.

Kim Farrar, CPhT, of the Harden Street Medicap Pharmacy in Burlington, NC assists patients who participate in the pharmacy's Blood Pressure Club.

Why do you think this new law is necessary and appropriate?

In our society everyone is held accountable. Pharmacy technicians are no different. This law will require a certain standard of training for all pharmacy technicians. Technicians will now be distinguished from cashiers that have been called technicians or assistants. There is a difference. The training that we are now required to receive will help assure the public of a certain quality in the person who is actually filling their prescription. The passing of this law is very appropriate. We live in a society that rightly demands standards for those practicing in health care. As members of the health care team, technicians can expect to be measured to a certain standard.

What do you see as the future role of pharmacy technicians?

We live in a time when the shortage of pharmacists is critical. With baby boomers becoming a large part of "aging" America, and with prescription numbers going up and up, someone has to step up and help relieve some of the burden for proper dispensing to the public. I see that as a role for pharmacy technicians. For many years we have been involved in all aspects of preparing the prescription. With pharmacists assuming more counseling responsibilities, there has to be someone with proper training who can do the repetitive work that doesn't have to involve a pharmacist.

I see the role of pharmacy technicians expanding even more to possibly include legislation for technician checking technician (tech-check-tech) in the repetitive refill of unit dose carts, floor stock item, refills and those activities that have originally been checked and double checked by a pharmacist. I believe there has to be a time when properly trained technicians are allowed some independence in the dispensing process. This would give pharmacists more time to use the valuable clinical knowledge they possess. It would take some of the stress and rush off of their shoulders and help cut down on mistakes made under such stress.

I see this as a benefit to the public who is rightfully crying out for their medications to be dispensed correctly.

Monumental Changes at Betsy Johnson Hospital

by Alyce Holmes

Betsy Johnson Regional Hospital (BJRH) is a 108 bed, non-profit community hospital located in Dunn. The pharmacy department has existed in different formats for at least 25 years, beginning with service from a local community pharmacy. Times have changed!

The pharmacy department is getting ready for a major improvement in our practice. In the next three years, the department's physical size will triple. No longer will staff have to look for a counter space in which to work or wonder where they can complete a task in a quiet space. In the 15 years that I have practiced at this facility, the changes have been monumental. It seemed at times as if no progress was made, but as I reflect back, I realize how much this department has achieved.

The Betsy Johnson Regional Hospital Pharmacy Department. Front row: Sherry Howard, PharmD, Alyce Holmes, PharmD, back row: Linda Toler, PharmD, and pharmacy technicians Mary Ann Barefoot, Lillian Blanchard, Bonnie Matthews, and Bobby Godwin.

Having practiced previously in the ivory tower of a large university hospital, the first time I came to BJRH it felt as though I was in a satellite pharmacy. The entire place consisted of one small room. There was unit-dose distribution and an IV additive service, but no computers. All patient profiles were handwritten, labels were typed, and billing was done manually. I felt as though I had stepped back in time. I didn't realize the journey that I had begun and how fulfilling it could be.

The management basics had been established, but there was a great need for the development of clinical pharmacist services. There were lots of opportunities, but first credibility had to be fostered with all departments and the medical staff. I learned the lesson of celebrating small victories in order to be able to accomplish more in the future.

It was important to develop a functioning Pharmacy and Therapeutics Committee. Through this avenue, many projects could be discussed and begun. For example, the first protocol that was ever approved dealt with parenteral nutrition and is in place in a revised version today. Beginning with one protocol, the department is now involved in many different clinical programs.

A computer system was installed that allowed for improved patient profiles and better tracking of medications and charges. Enhanced checking of drug-drug and drug-food interactions became available. Since the system is hospital-wide, pharmacists have access to needed laboratory values when assessing patient information. The computer also generates medication administration records (MAR) and labels. A FAX machine is now used to send orders to the pharmacy, and communication between nursing and pharmacy has greatly improved.

Our technicians are very involved in hospital projects. They have been a major part of the Needlestick Prevention Team which is in the process of converting the hospital to a needleless system. Tracking of vaccine use and working with Employee Health are also part of their responsibilities. Our technicians work diligently to maintain an appropriate inventory and have, over the past years, improved the process for taking an inventory yearly. Proximity to Campbell University School of Pharmacy has allowed the department to hire pharmacy students as relief technicians. It is exciting to be part of their growth and at present the staff includes three pharmacists who began their careers as technicians at BJRH.

The pharmacists now make contributions to many hospital-wide teams, including Care of Patient, Resuscitation, Patient Safety, Patient Assessment, Conscious Sedation, and Infection Control. Pharmacists have led the hospital efforts for the National Registry of Myocardial Infarction (NMRI) and the Living Well with Diabetes Program. NRMI-III has become an outcomes measure for JCAHO. A pharmacist has done a major presentation at each of the last three JCAHO inspections. The diabetes program has been certified by the American Diabetes Association (so that the program can bill) and the pharmacist, a nurse and dietitian have become Certified Diabetes Educators.

Aminoglycoside consults by pharmacists are routine. There is a policy for therapeutic substitutions which improves formulary management. A weight based heparin protocol was established. A grant from the Kate B. Reynolds Foundation

allowed us to begin a program to help our needy patients at discharge with purchase of medications. Pharmacists monitor troponin levels, INR and renal function daily with reports automatically generated to the department by the laboratory. A Coumadin® education pathway was begun.

The hospital has also recruited pediatricians to the area and as a result, our pediatric medication orders have increased substantially. Dealing with issues of patient safety in this population has been a challenge. The staff, in conjunction with the Pharmacy & Therapeutics Committee, developed extensive charts which could be used by nurses for the administration of medications, and by pharmacy technicians for the dilution and preparation of pediatric medications. This standardization of concentrations helps to prevent medication errors while making the best use of our knowledge.

Three years ago, an oncology pharmacy was established in conjunction with physicians from Cape Fear Valley Oncology. Equipment was purchased, policies and procedures were developed and staff was thoroughly trained regarding oncology protocols and OSHA requirements. Since safety is one of our top priorities, multiple checks and balances were put in place when the program began. For example, standardized orders were put into the computer which included all the information required for the pharmacist to double check all orders against protocols and patient specific data.

Pharmacists also serve as preceptors to students from both Campbell University and the University of North Carolina School of Pharmacy. We think that this small department has much to offer a student in terms of the "reality" of practice in a small, rural hospital. Practical experience and the constant use of things that students are taught create a stimulating rotation, whether it is clinical or administrative in nature.

Opportunities abound for improving pharmaceutical care at our institution, and we are trying to take advantage of these. A caring, competent staff provides high quality service to our patients, medical staff and fellow employees. We are proud to be a part of the institution and hope to continue to improve and grow at our practice site. ❖

About the Author...

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CONTINUING EDUCATION

In order to better serve our members, NCAP will mail a special CE Supplement only to members who request it. CE is no longer published in *North Carolina Pharmacist*, leaving more room for news of interest to all readers. As always, Continuing Education is available only to members. Members who would like to be added to the mailing list for CE should contact Teressa Reavis at teressa@ncpharmacists.org or call 919.967.2237 ext. 27.

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Clinical Corner

A Pharmacist's Role in Pain Management

At Duke University Medical Center (DUMC) all pharmacists are encouraged to play a role in the management of pain. Clinical pharmacists round with many inpatient services as part of the multidisciplinary teams providing patient care. Pharmacists are available to answer questions regarding Patient Controlled Analgesia (PCA), drug selection and dosing. The pharmacy department also provides access for physicians and nurses to pain management specialists. Two clinical pharmacy specialists provide daily rounding with 24/7 beeper availability to answer questions after hours. These pharmacists round on ten to 25 patients a day. The pharmacists are associated with and report daily to the pain service attending physician but round independently.

by Joal Glasson

Services provided by the pharmacy pain specialists, throughout the hospital, include sickle cell pain management, management of complex PCA therapy patients, analgesic dose conversions and therapy transition management, pain management complicated by addiction and substance abuse, side effect management, and recommendations for continuum of care after discharge. An important part of our work is to provide clinical education to health care providers about pain management.

The opportunities and roles in our specialty practice mirror those contributions that pharmacists in other practice settings can provide, improving patient outcomes with pharmacologic pain management therapies. There is great potential for the pharmacist to improve the quality of life of patients with pain. This is a primary motivating factor, encouraging those involved as advocates for their patient's pain management.

Hospital pharmacists are expected by JCAHO to participate in formulating safe practice guidelines for medication administration devices including PCA therapy. At DUMC, the pharmacists participate in opioid dosing decisions guided by weight referenced PCA dosing and rational opioid conversion strategies supported by clinical training and knowledge. These are likely opportunities for clinical practice in all hospital settings.

The patient with acute pain using opioids often experiences side effects, which complicate therapy. These side effects include sedation, nausea, pruritis, altered mental status, urinary retention, respiratory depression and constipation. Tolerance to respiratory depression occurs rapidly, allowing safe titration of opioid therapy in severe pain. [1] Tolerance to other side effects develop within days to a couple of weeks, except for constipation.

Constipation with opioids is always expected and any patient using opioids should receive counseling regarding prevention, regular assessment and appropriate management. Complicating patient factors include immobility, advanced age, abdominal disease or surgery, and contributing effects of other medications e.g. anticholinergics. Appropriate pharmacotherapy focuses on stool softeners with mild peristaltic stimulants. Inappropriate therapy with bulk fiber laxatives causes fecal impaction and obstruction. Osmotic laxatives are helpful but should not be used in patients with impaction or obstruction. Avoid saline laxatives for patients with sodium restrictions. Enemas and suppositories are appropriate aggressive therapy, but should be avoided in the neutropenic oncology patient.

Nausea from opioid therapy is caused by mechanisms involving slowed GI mobility, sensitizing effects on the vestibular system, and stimulation of the chemoreceptor trigger zone. Usually the nausea is most prominent with initial opioid dosing, larger doses, or rapid onset of drug effect. Often adjustment of dose or opioid selection resolves nausea concerns. Some patients are nauseated from all opioids and note a prominence of nausea with opioid use and any movement. These patients often have a history of motion sickness. Transdermal scopolamine or meclizine is often the solution to this challenging barrier to opioid use. Carefully reviewing patient history for contraindications to the use of these agents and consideration of their side effects is an important pharmacist responsibility.

Some standard therapies of the past are clinically proven to be minimally effective and provide significant risks to patients. Progression of knowledge and patient care are not provided with repetition of error. Propoxyphene[2] and codeine[3] products have questionable efficacy. Propoxyphene and oral meperidine have significant toxic effects from their metabolites and are not recommended for use by the American Pain Society.[4] A recent study highlights the risks of developing chronic renal disease with regular use of APAP/opioid combination products in those patients with impaired renal function.[5] Neuropathic pain can be more effectively treated with non-opioid adjunctive agents, reducing opioid use and related side effects. If pharmacists are to be effective patient advocates in resolving pain management problems, they must be current and knowledgeable regarding concepts of pharmacologic pain management. Continuing education for practicing pharmacists, and a greater emphasis in student curriculums on pain management, is needed to maximize the potential of pharmacists to reduce their patient's pain and discomfort.

Pharmacists are a readily available source of information for the public and other health care providers. Pharmacists should take a leading role in the health care team, advocating rational, safe and effective pharmacologic pain management therapies wherever their practice may be.

[1] Foley KM. Misconceptions and controversies regarding the use of opioids in cancer pain. Anti-Cancer Drugs 6 (suppl 3) 4-13,1995

[2] Li Wan Po A. Systematic overview of co-proxamol to assess analgesic effects of addition of dextropropoxyphene to paracetamol BMJ 1997;315:11565-71

[3] Zhang WY, Li Wan Po A. Analgesic efficacy of paracetamol and its combination with codeine and caffeine in surgical pain—a meta-analysis. J of Clinical Pharmacy & Therapeutics 1996 21(4):261-82.

[4] Principles of analgesic use in the treatment of acute pain and cancer pain. 4th Edition. American Pain Society 1999.

[5] Fored CM et al. Acetaminophen, Aspirin, and Chronic Renal Failure. N Engl J Med 2001:345; 1801-08

About the Author...

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Residency Gives You Confidence to Pursue Dreams

"Pharmacy school prepares you for clinical rotations, rotations prepare you to be a pharmacist, but a residency prepares you to be a clinician."

These are the words of a residency candidate that I recently interviewed for one of the pharmacy practice residency positions at Pitt County Memorial Hospital (PCMH) in Greenville, North Carolina. I am one of the current pharmacy practice residents, and at this crunch time of the year, I needed to be reminded why I have put myself through this grueling year.

by Kennedy P. Blount

This has been one of the most valuable learning experiences of my life. I received my Doctor of Pharmacy from Campbell University School of Pharmacy, and completed many of my clinical rotations at PCMH. My pharmacy education and training prepared me with the base knowledge to gain the most out of this year. I chose to do a residency to obtain an enhanced clinical knowledge from some of the best in the business. The clinical pharmacists at PCMH are highly skilled and are very well respected by both the medical and nursing staffs. Throughout this year I have had the opportunity to learn from their experiences and take away the therapeutic caveats that you simply cannot learn from books. Another advantage of a residency is the opportunity to see and experience many different clinical avenues. I have had the opportunity to rotate through twelve different areas of the hospital. This has allowed me to gain a better sense of my strengths and weaknesses as well as my likes and dislikes.

Besides the short-term goal of completing a pharmacy practice residency, I hope to one day pursue a faculty position at a school of pharmacy. A variety of teaching opportunities ranging from precepting students, to providing clinical information as part of an inpatient medical team, has underscored my desire to teach others. I also hope to use the clinical skills I have gained this year to initiate new clinical programs to benefit the outpatient services provided by PCMH. The residency year gives you the confidence to pursue your dreams.

A residency also gives you a clinical edge that cannot be obtained by clinical rotations alone. As a student, you always have a safety net to catch you if you fall; in a residency program the net is there, but it is closer to the ground. Suggesting drug regimen changes as a student requires preceptor approval. During a residency and as a licensed pharmacist, independent thinking and clinical contributions to the team are encouraged. This experience offers you a chance to get your feet wet as a clinician and provides a wonderful learning opportunity.

> *"As a student, you always have a safety net to catch you if you fall; in a residency program the net is there, but it is closer to the ground."*

Another difference from student to resident, is the added responsibility of meeting participation. Meeting topics range from clinical therapeutics and projects to staffing issues. Participation allows the resident to become involved in departmental policy and drug protocol development. Perhaps more importantly, involvement allows the resident to experience a variety of clinical opportunities in a fairly short time frame. A typical week consists of daily morning rounds; lunch meetings consisting of pharmacist noon conference, journal club, and committee meetings (i.e., medication safety, pharmacy and therapeutics, antibiotic use, and longitudinal pharmacy management) and afternoon discussions with your preceptor. Every other Monday we see patients in ambulatory care pharmacotherapy clinic. We educate patients about diabetes or other chronic disease states or see patient referrals for medication management. I have completed various projects this year including a medication use evaluation of metformin, and have written a nonformulary acquisition policy. The other resident and I also alternate staffing every other weekend.

The residency research project is another requirement of an accredited program. I chose to work with the trauma department of the East Carolina School of Medicine to prospectively evaluate aminoglycoside levels in trauma patients. I have collected various clinical parameters on 85 patients that will be compiled and presented at the Southeastern Residency Conference at the end of April in Athens, Georgia. I have learned a great deal about clinical research by completing this project including literature review, the Institutional Review Board process, data collection, and statistics. This project is part one of an ongoing trauma study that will further evaluate aminoglycoside pharmacokinetic differences in trauma patients.

It is hard to believe that there are only three months remaining in my residency. I have learned an incredible amount since July. Although this year has been extremely busy and hectic at times, when asked if I would do it again, I would say, you bet!

About the Author...

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Medical Savings Accounts and North Carolina Pharmacy

by Chad Riggs, PharmD Candidate
Campbell University School of Pharmacy

For the last several years, the United States health care system has conducted a massive experiment. Can managed care, whether publicly or privately funded, lower costs and improve patient care? Ladies and gentlemen, the jury has reached a verdict and the answer is a resounding "NO!" Providers aren't happy; patients aren't happy. The only groups that are smiling are the managed care companies. The rest of us are miserable.

Given that, I think it's fair to ask ourselves (as providers and consumers of health care) how much more we're willing to take. At what point do we say this current system of health care is not working; it's not repairable? In the past several years, I've been fascinated with the lengths to which some are willing to go in order to try to make the current system work. Proposals have been put forth that patch here and tinker there, but in the end nothing really improves; professional fees and working margins continue to decline. In the process, we make ourselves look like we're begging for scraps; we'll take whatever government and private insurance companies will offer.

To complicate matters further, our state and national politicians are preparing to bring their "expertise" to the bargaining table. Their solution is an outpatient prescription drug program for seniors through Medicare.

It's my belief that such a broad invasion into the health care system by the government will not solve the problem. It will only exacerbate it. The flaw in the current system is a fundamental one; it can't be salvaged. Our system has succeeded in removing the influence of free market forces by the use of "third-party payers" and co-pays. The consumer is no longer responsible for paying the bill, and most consumers are unaware of the total cost associated with a given health care service. In that environment, there is no economic cost containment and overuse of health care resources is encouraged. As long as the public perceives someone else picking up the tab, they will continue to see their physicians for every sniffle and pop a pill for every ailment. It's human nature.

The **only** tested and proven way to contain costs in any industry is through competition and free market forces. The **only** way to have these forces as a part of any industry is to allow consumers to pay for goods and services directly. The incentive to make cost-conscious decisions is what allows the consumer to establish the price in the marketplace, to establish "what the market will bear." It's worked in every industry in which it's been tried. When VCRs hit the market in the early 1980's, the average price for a unit was around $1,000. Today you can pick one up at any mass-market store for less than $100. The same can be said for cell phones, DVD players, and computers. The *consumer*, through direct purchasing power, has set the price for each of these items. It's what our system of trade is based on....freedom and capitalist economic structure.

How do we bring this concept to health care? Medical savings accounts (MSA's) are a great alternative to the cradle-to-grave coverage being offered by HMO's and some government programs. The idea behind medical savings accounts is that people are allowed to opt for high-deductible catastrophic insurance coverage rather than a low-deductible, ultra-comprehensive policy. Consumers would use the premium savings to establish a tax-free medical savings account out of which routine medical expenses would be paid. Consumers have the cash up front to pay for relatively inexpensive medical services (regular office visits, prescription medications, immunizations, etc.) yet there is an incentive to spend those dollars wisely as consumers may withdraw a portion of the MSA funds at year's end. The money could be used to finance a vacation, make a downpayment on a new car or a house, or transferred to an IRA. Alternatively, the funds may be left in the MSA and rolled over to the next year. Other consumer benefits include:

- The annual contribution to an MSA is made with pre-tax dollars
- When MSA investment funds are used for qualified medical expenses, they are tax-exempt
- Funds in an MSA typically earn 4-5% interest and these earnings are also tax-exempt
- Accumulated MSA funds do NOT prevent you from depositing the maximum allowable contribution to your MSA every year

- If you change jobs your MSA stays with you

The point is this: the consumer is exposed to the total cost of the goods and services, and there is an incentive to make cost-conscious decisions. MSAs cut the "middleman" and allow the consumer to retain any savings that are generated as a result of more prudent decision making in health care.

What are the benefits of MSA's to health care providers? They would result in the elimination of prescription drug formularies, appeals for coverage, lack of portability, and huge administrative costs. With an MSA, the consumer is the final arbiter on whether or not a drug is "covered." There would be no phone calls or forms to fill out in order to appeal a certain medication for coverage. For a patient with an MSA, the only people involved with making health care decisions are those with the patient's well-being as their top priority: the patient, the physician, the pharmacist, and other health care providers. In addition, providers will be given the freedom to establish their own fair price for the goods and services they offer.

Is there proof that MSA's actually work? The evidence is overwhelming in favor of a free market approach! In a study done by the National Bureau of Economic Research of 300,000 employees of Fortune 500 Companies over three years, 90% of the workers would have saved over $25,000 each by retirement by using an MSA, even without altering their spending habits. Twenty-seven Ohio firms who offer MSA's to their employees have found that their health care costs have dropped by 12% to 40%. A study done by the Rand Corporation showed that people spend 30% less on health care without adverse effects when they spend their own money. Savings will be immediately available just by eliminating the managed care administrators and allowing people to shop for their own health care services. The Actuarial Firm of Milliman and Robertson has estimated that MSA's would lower the nation's annual health care bill by $300 billion.

We need to be a vocal force in the debate on the direction of the health care system, not only for our well-being but for that of our patients. Bringing medical savings accounts to the discussion table with our patients, fellow health care professionals and the North Carolina General Assembly is our job. The long-term benefits and preservation of quality patient care depends on it.

More information can be found at the following:

- Cato Institute (http://www.cato.org)
- Heritage Foundation (http://www.heritage.org)
- National Center for Policy Analysis (http://www.ncpa.org)
- Urban Institute (http://www.urban.org)
- Cascade Policy Institute (http://www.cascadepolicy.org)
- Buckeye Institute (http://www.buckeyeinstitute.org)
- Free Market Medicine (http://www.marketmed.org)
- John Locke Foundation (http://www.johnlocke.org)

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The North Carolina Association of Pharmacists welcomes submissions of editorials, letters to the editor, and opinion pieces to be published in *North Carolina Pharmacist* or on the NCAP web site at www.ncpharmacist.org. Please contact NCAP for more information and submission guidelines.

Challenges at NeighborCare Pharmacy Services Rewarding

by Susan Hoy

Long-term care consultant pharmacy services provides a pharmacist with the opportunity to use every avenue of the profession to improve medication therapy for the elderly patient. This is a unique characteristic that makes this particular career in pharmacy extremely rewarding.

As a long-term care pharmacist (LTCP), I enjoy the opportunity to interact with various other health care team members to examine and provide input in choosing the best possible drug regimen for the patient.

LTCP's are respected members of the health team and relied on for decisions in appropriate care of the elderly.

CMS (previously HCFA) guidelines provide the LTCP with a monthly regulatory focus. Charts in a LTC skilled facility must receive a Drug Regimen Review every 30 days. Assisted Living level of care must be reviewed every 90 days. On the monthly review, the LTCP assesses the drug regimen for each resident on the basis of multiple criteria. Herein, the opportunity to use every avenue of pharmacy!

LTCP's provide an in-depth review of each active chart in terms of appropriate drug therapy as related to the current condition of the resident, assessment of outcomes, review for unnecessary medication therapy or length of therapy, adverse reactions, drug interactions, drug storage and handling, and appropriate medication administration. The chart review process is essential not only to assess the therapy of the resident, but to allow the pharmacist to document and follow the resident's drug regimen responses and outcomes.

Based on this review, pharmacists provide instruction to the staff regarding necessary monitoring, changes, and sometimes error potential regarding medications.

LTCP's often take on a teaching role for select disciplines of the health care team. Medication Administration is the expertise of the pharmacist. Observation and instruction to the nursing staff not only teaches proper medication administration, but allows the staff to interact and learn from the pharmacist about appropriate techniques, infection control issues, regulatory compliance, etc. Working sometimes with staff through inservices, and frequently one-on-one with nurses, provides an excellent opportunity for nurses to interact with the pharmacist.

LTCP's work directly with physicians to choose appropriate drug therapy for the unique elderly resident. Doctors often rely on the pharmacist to ensure that therapy is accurate and safe for the resident. Remember that this population is different from any other. Whereas changes in therapy for the general population are tolerated well for the most part, in this group of patients, the slightest change in dose may result in severe changes in status.

LTC regulations also mandate that special arenas of therapy be closely controlled. Psychoactive therapies in the elderly must be monitored for effectiveness and appropriateness on a regular basis. What better source to monitor this than the medication expert!

As the challenges with reimbursement grow in this industry, the LTCP is challenged with trying to manage therapy for the complex resident not only for positive therapeutic outcomes, but also for cost effectiveness. It is a huge task to manage the resident with 15 to 20 different medications for possible drug interactions. It is also a huge task to try to reduce those medications when possible to find the lowest possible effective dose. Now the pharmacist must also work to reduce the total number of medications for residents. We are now working to incorporate Evidence-Based Medicine into our practice in an effort to choose cost effective drug management regimens for the elderly. Restrictions on State Medicaid and Medicare reimbursements have challenged the consultant pharmacist to be creative and aggressive in trying to decrease drug utilization as well.

As previously mentioned, federal regulations mandate that drug regimen reviews be preformed. Therefore, the need for services is established. But how does the consultant pharmacist expand this role to develop a practice that not only encompasses regulations, but also enhances their practice? By developing productive ways to induce reliability on the consultant pharmacist and by charging for these services.

Currently the nursing home relies on the consultant pharmacist to review charts, recommend changes in drug therapy and manage drug delivery systems. Now we are beginning to step beyond that. Minimum Data Set (MDS) reviews by a pharmacist can now help the nursing home capture additional money from the federal government. Pharmacist input can impact assistance in Care planning of resident activities which may be affected by drug therapy. And as mentioned earlier, ways to reduce drug cost through therapeutic interchange programs and management of drug choices can be managed most appropriately by the consultant pharmacist. All of these offer the opportunity for pharmacists to enhance their role and be reimbursed for services.

Nursing Staff is challenged to provide appropriate care in the ever-tightening grasps of financial cutbacks. Time is limited for them. The input of the pharmacist while reviewing charts is

quite frequently the critical point in deciding appropriate action for the elderly patient. The pharmacist's ability to examine and evaluate information on the chart provides an assessment that is essential for appropriate care.

Recently one of our consultant pharmacists visited a nursing home to provide a routine drug regimen review. On chart inspection, she found a resident who had a CBC lab result revealing a low Hct from two weeks prior. The staff had appropriately alerted the physician of this lab. The physician responded with an order to monitor this lab again in ten days. As ordered, ten days later the lab was redrawn and results sent to the physician. What the consultant review brought to this situation was critical. A nursing assistant reported that morning that the resident had diarrhea. Review of the chart reports showed a drop in Hct between the two lab draws. The pharmacist suggested that the nurse check for a hemocult positive stool. Positive stool resulted in the discovery of a "Silent" GI bleed. Quick assessment and reaction by the pharmacist probably saved this elderly resident's life.

Rewarding? Yes. Difficult? Yes. Exciting? Definitely YES!

Consulting pharmacy is a unique arena of pharmacy. It involves all aspects of the profession, all of the time. Consultants love what they do. They love the challenge. They love the rewards. They love making a difference every day!

About the Author...

Susan H. Hoy, RPh, FASCP, is Area Clinical Manager for NeighborCare Pharmacy Services of North Carolina in Huntersville. She can be reached via e-mail at Susan.Hoy@ghv.com

CDC Advisory Group Releases Next Season's Recommendations on Flu Prevention, Treatment

When the flu-vaccination season starts in October 2002, health care providers should first administer the vaccine to persons at the greatest risk for influenza-related complications and other health care workers, according to new recommendations from the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices. The advisory group also encourages influenza vaccination of healthy children ages 6-23 months and notes the upcoming availability of a small supply of single-dose syringes containing influenza vaccine and a reduced thimerosal content. For more information visit http://www.cdc.gov/mmwr/PDF/rr/rr5103.pdf

Rural Health Care at Scotland Neck Family Medical Center

As a clinical pharmacist in a rural health center, I have been employed at Scotland Neck Family Medical Center for five years. My role is part of a team that consists of physicians, PA's, and one clinical pharmacist. As the clinical pharmacist, I see patients with a variety of chronic diseases such as diabetes, hypertension, hyperlipidemia, CHF, CAD, asthma, and depression. The providers refer patients who are uncontrolled in their disease state(s), and I provide education, disease state management, and follow-up.

by Martha Whitaker Jones

One of the providers, for instance, may refer a patient with a HgbA1C of 12%, a blood pressure of 150/90 and an LDL of 140. I begin with education about diet and exercise and review medication compliance. Then I decide which labs need to be checked and which medications need to be adjusted. I do a physical assessment, listen to the heart and lungs, and check for edema. In patients with diabetes, I do regular foot exams and monofilament testing. I review each system and side effects of medications and take a complete medication history, including OTC's and herbals. Then, I report to the provider my findings and recommendations, and the provider briefly sees the patient. I try to optimize preventive health, including flu shots, mammograms, cancer screenings, eye exams, dental care, EKG's, etc.

The billing/coding is done by the provider. However, my administrator knows that the providers can be much more efficient, and see more patients per hour, if they have the pharmacist see many of the complicated, chronic disease patients. Most of my visits are billed at the 99214 level.

I keep a flow sheet to follow patients with diabetes and a flow sheet to follow warfarin patients, as well as a general medication flow sheet that is updated at each visit. These forms help with continuity among the providers and with tracking adverse events and current doses. Under a physician's supervision, I have a protocol to adjust warfarin doses. I also have developed a refill protocol which enables automatic refill of medications that are used for chronic diseases.

A large part of my job is my role as a community based faculty member with the UNC School of Pharmacy and AREA L AHEC. I directly precept pharmacy students and demonstrate how to take medication histories, practice physical assessment skills, and make rational recommendations to the providers. I also enjoy helping train students from other disciplines (medical, PA, NP, etc), showing them what a pharmacist can do in a rural health practice.

"My next task is to write disease state management protocols in order to apply as a clinical pharmacist practitioner. With the CPP status, I should be able to obtain a provider number and begin billing directly."

A unique part of my practice in a rural community is weekly home visits to patients who have difficulty getting into the office. Our team consists of a PA, a clinical pharmacist, a nurse, and various students. My role is to review medications, assess barriers to compliance, and stop any unnecessary agents. I try to simplify regimens and provide education and disease state management. I also personally fill pill boxes monthly for many elderly patients.

When I first began practicing in rural health, I recognized that one of the main barriers to compliance was financial difficulties. Many patients were uninsured, especially farm workers and domestic help, and many patients were elderly, with only Medicare, which does not provide assistance for medications. I initiated (and now maintain) a patient assistance program for indigent patients to obtain medicine through various pharmaceutical companies. Two assistants, under my supervision, maintain the free medicine program. We average $40,000 worth of free medicine for our community each month.

My next task is to write disease state management protocols in order to apply as a clinical pharmacist practitioner. With the CPP status, I should be able to obtain a provider number and begin billing directly. I believe that my value as a provider is already established in my practice site, but it will be nice to show some numbers to my administrator! Also, since there will be less waiting time for the physician provider to review each case, the visit should be shorter and more efficient for the patient.

There are many positive reasons to work in rural health. One of the best reasons is the opportunity to get to know your patients, as well as their families. You begin to feel that you are an integral part of the community and that you are making a difference in patient care.

About the Author...

Martha Whitaker Jones, PharmD, is Director of Pharmacotherapy, at AREA L AHEC, Scotland Neck, and Clinical Assistant Professor at the UNC School of Pharmacy. She can be reached via e-mail at mwjones@med.unc.edu

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- **Echinacea** might interact with lovastatin and other statins
- **Kava** is causing liver toxicity... including some failures and death
- **Valerian** might inhibit metabolism of ketoconazole and fexofenadine
- **Coenzyme Q10** can disrupt chemotherapy
- **Garlic** decreases effectiveness of HIV protease inhibitors
- **Soy** can decrease the effectiveness of tamoxifen for breast cancer

Then Pharmacist's Letter created wonderful new charts... see **what natural meds might work for a particular condition**... significant Drug/Herb interactions for you to watch out for... and **Herb/Drug interactions**, too. Very useful. And the new **Brand Name Product listing** tells you what's in thousands of products... including all sorts of new products. Patients will be impressed when you always know what's in anything they ask about.

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Small Doses

Congratulations to CGP's

NCAP members Cecil M. Davis of Winston-Salem, Todd King of Lillington, Chad L. Terry of Kinston, and Mary Beth W. Terry of Kinston have been accredited as Certified Geriatric Pharmacists by the Commission for Certification in Geriatric Pharmacy. The CCGP conducted its ninth Certification Examination in Geriatric Pharmacy in November, 2001. Seventy-seven U.S. and Australian pharmacists, representing a variety of practice environments, sat for the exam, of which 68 candidates earned a passing score

Johnson Receives NIH Grant

Melissa Johnson, PharmD, a clinical assistant professor in the Department of Pharmacy Practice in Campbell University's School of Pharmacy, recently received a $762,205 grant from the National Institutes of Health (NIH) to study a fungus known as Candida. The grant, a five-year award, supports the development of the independent research scientist in the clinical arena. She is the first pharmacist to receive this type of career development award from National Institutes of Allergy and Infectious Diseases.

According to Johnson, who is also a 1997 PharmD graduate of Campbell, the "Mentored Patient-Oriented Research Career Development Award" is the federal government's way of increasing the number of people doing clinical research. The NIH is especially interested in increasing the number of clinicians trained to conduct high-quality, patient-oriented clinical research.

Johnson's project, "Host Response Factors Among Patients with Invasive Candidiasis," involves the unprecedented study of over 700 patients to systematically evaluate select factors associated with outcomes among patients with fungal infections caused by specific types of Candida called albicans and non-albicans. Invasive candidiasis is a fungal infection that occurs when Candida species enter the blood, causing bloodstream infection and then spreading throughout the body.

Eckel Appointed Editor-in-Chief

The publishers of *Pharmacy Times* recently announced the appointment of Fred Eckel as Editor-in-Chief. Fred currently serves as Executive Director of NCAP and is a professor at the University of North Carolina at Chapel Hill School of Pharmacy. He is past president of the American Society of Health-System Pharmacists and has served as a member of the *Pharmacy Times* Editorial Advisory Board for over 12 years.

"Pharmacy has been an important part of my life since I became licensed to practice in 1961. I have shared my perspectives on pharmacy in 49 states and on five continents. Both of my children are pharmacists, suggesting that I see a bright future for this profession, and I do. Using this new role as Editor-in-Chief of *Pharmacy Times*, I hope to chronicle pharmacy's progress and contribute my small part to its advancement," he said.

CPFI Meets in June

Several NCAP members are scheduled to speak at Christian Pharmacists Fellowship International's annual meeting June 21-26, 2002 in Myrtle Beach, SC. Speakers include Larry Swanson, PharmD, Professor at Campbell University School of Pharmacy, Stephen F. Eckel, PharmD, Operations Manager at UNC Hospitals, Fred Eckel, MS, Executive Director of NCAP, and Daniel W. Teat, PharmD, Assistant Dean, Campbell University School of Pharmacy.For more information about this meeting contact CPFI at 1-888-253-6885 or e-mail office@cpfi.org

VIAL OF LIFE

NCAP Auxiliary Urges Your Participation in Vial of Life Program

The NCAP Auxiliary would like to encourage you to participate in the Vial of Life program. The program is designed to provide important medical information to emergency medical personnel. Quick access to current medical and prescription information during an emergency is essential for everyone, particularly for those who live alone or have special medical needs.

Here's how the program works. Pharmacists provide a 16 dram snap cap vial, two Vial of Life stickers, and a medical history form to a patient. The patient is instructed to complete the medical history form, place it in the vial and attach a Vial of Life sticker. The second sticker is placed on the outside of the patient's refrigerator and the vial is placed inside the refrigerator on the top right hand shelf. It would be helpful if pharmacists would assist in completing the medical history form and provide a printout of the patient's prescription record. Emergency medical personnel are trained to check the refrigerator for a Vial of Life sticker and look inside for the vial containing medical information.

The Auxiliary would like to encourage your continued participation in this project. Vial of Life stickers and medical history forms can be obtained from the NCAP Auxiliary at 109 Church St., Chapel Hill, NC 27516, ph: 919.967.2237. Stickers are $0.04 and medical history forms are $0.05.

Calendar

May 14-16: ***The American Society of Consultant Pharmacists Geriatrics '02 Midyear Conference and Exhibition***, Caesars Palace, Las Vegas, NV. For more information visit www.ascp.com

May 19-21: ***The National Community Pharmacists Association's 34th Annual Conference on National Legislation & Public Affairs***, Loews L'Enfant Plaza Hotel, Washington, DC. For more information call 800.544.7447 or visit www.ncpanet.org

June 1-5: ***The American Society of Health-System Pharmacists Summer Meeting 2002***, Baltimore, MD. For more information visit www.ashap.org and click on Meetings and Education.

July 19: ***3rd Annual NC Residents Leadership Conference***, Alamance Regional Hospital, 10:30 am - 4:30 pm. Open to all NC residents and preceptors. Call NCAP for more information.

Oct. 9-11: ***NCAP Annual Convention***, Sheraton Four Seasons, Greensboro, NC. For more information call 919.967.2237 ext. 22 or visit the NCAP web site at www.ncpharmacists.org

Tech Talk

A Good Pharmacist Can Be Even Better With a Good Technician

by Sandi Smith

The purpose of certifying pharmacy technicians is to assure and standardize their capabilities in assisting pharmacists in performing their duties. There is a shortage of pharmacists and that is directly affecting patient care. Pharmacy technicians are stepping up to the plate. There should be a standard certification set for pharmacy technicians. Pharmacists used to have the time to train technicians "on-the-job," but due to increased responsibilities, pharmacists need someone who already has the training and experience to handle the job.

Pharmacy technicians are actively filling carts or prescriptions, preparing IV admixtures, entering physician orders, unit-dosing medications, assisting with compounding, and performing various other tasks. Everyone should have training and a basic understanding of their duties. Having certified technicians ensures pharmacists that the technicians have met the minimal requirements needed for the position.

As with any job, you must learn to cooperate with and earn the trust of fellow employees. A good pharmacist can be even better with a good technician. Once the technician has demonstrated high competency, he or she can assist the pharmacist in many ways. Managing inventory, acting as medication safety officer, or filing insurance claims are good examples of things technicians can do. It solely depends on the trust the pharmacist has in you and the capabilities he or she feels you have.

There is no reason why a pharmacist should be tied up on the phone handling an insurance problem when a technician is capable of dealing with the situation. Pharmacists need to spend more time counseling patients and working with other health care professionals to improve patient care. The bottom line is pharmacy prescription totals have exploded with a decrease in the number of pharmacists. Wouldn't you feel better about having your prescription filled by a certified technician verses non-certified? I am not stating that non-certified techs are incapable of the performing their job. We do, however, have to assure the general public, as well as the pharmacists, that we are well-educated and accountable for our role.

I feel that there will be an increase in pay for certified technicians in the near future. This does not come without a price, however. It is also important for pharmacy technicians to be registered with their boards of pharmacy—this will provide a method of technician tracking. The tracking method is designed to protect pharmacies from hiring negligent technicians as well as pharmacists; it is not designed to harm you. Furthermore, pharmacy technicians should be held accountable for their actions. We cannot continue to avoid responsibility by treating all mistakes solely as "pharmacist" mistakes.

There are so many avenues opening up for certified technicians. Our job responsibilities are expanding, and we are finally receiving recognition. Embracing certification as a means of ensuring competency will only enhance our acceptance and viability in the health care system. ❖

About the Author...
Sandi Smith, CPhT, works at Onslow Memorial Hospital in Jacksonville, NC. She can be reached via e-mail at sandra.smith@onslowmemorial.org

Why Pharmacy Technicians are Taking NCAP's Review Seminar

Over the past three years, many people have taken NCAP's Technician Review course with high hopes of passing the PTCB exam. We always ask why they came to the class and more importantly, why they want to become certified. Here are some of the answers:

• Technicians want to increase their salaries and if certification gives them the opportunity to "climb the ladder," why not take the test.

• Certification is the next step that states will be taking in relation to improving the quality of pharmacy. Certified techs will be an integral part in the pharmacy team and in order to stay on the cutting edge, techs need to prepare and take the test.

• In some states, certification is mandatory in order to be a pharmacy technician. There are some companies that also require their techs to be certified. The job market opens up for those qualified techs, while others may be left in the cold.

• Some techs want the respect that comes along with a certificate on the wall stating that he/she has successfully passed the exam for certification. They can prove that they have mastered the skills necessary to be a good technician.

• Many techs feel a sense of accomplishment when they pass the test and are now part of a professional team. They try harder, they read more about their profession, and they even have more meaningful responsibilities.

• Some techs take the exam in preparation for pharmacy school. The PTCB web site's practice exam is a rigorous insight into the knowledge needed, not only to pass the test, but also in the day-to-day activities in the pharmacy.

Many people taking the exam may be fearful of being passed over in their position if they don't improve their skills and become certified. Mandatory certification is not just in the future; it is in the near future. Many state requirements are paving the way for certification. Tech registration with the Board of Pharmacy is the first step toward regulating the technician field. The legislation allowing an increase in the ratio of pharmacists to technicians who are certified shows the future need for these techs. Ultimately, the pharmacist-technician bond will not only strengthen but also augment each other in their daily activities. We pharmacists should not only support our techs toward certification, we should promote their interest in becoming certified. It is their future that will make the profession of pharmacy brighter. ❖

The Authors, Ted Spader, RPh, and Mark Sheppard, RPh instruct the NCAP Technician Review Course. See page 23 for a complete registration form.

In North Carolina 315 pharmacy technicians sat for the Phamacy Technician Certification Board Exam on November 10, 2001. An astounding 89% of those candidates passed the exam, far exceeding the national average of a 79% passing rate. Congratulations to North Carolina's new CPhT's.

NCAP presents a great opportunity for technicians in your pharmacy...

North Carolina Association of Pharmacists
Technician Review Seminar

This one-day review has something for all technicians:

- ✔ **Prepare for the Pharmacy Technician Certification Board Exam.**
- ✔ **If you are already certified, earn 7 hours of CE credit.**
- ✔ **As of July 1, 2002 the Board of Pharmacy requires that all new technicians complete a formal training program. This course fully meets the BOP training requirements.**

NOTE: May 31 is the deadline to register for the July 27, 2002 PTCB Exam. To receive a PTCB Exam registration packet visit www.ptcb.org, call PTCB at 202-429-7576 or call NCAP at 919-967-2237.

The availability of a review class prior to taking an exam is an advantage that most people would welcome. With new legislation recognizing the benefits of national certification of technicians, the advantages that this program provides will far exceed the minimal costs involved.

Over 98% of the Technicians who have taken this review course have passed the PTCB exam.

These success stories speak highly of the presentation materials and the instructors:

- Ted Spader, RPh, MSPhAd is employed with the Eckerd Corporation. He has worked at Somerset Medical Center, is the previous owner of Ringoes Pharmacy, Inc. and was previously a District Manager with Eckerd.
- Mark Sheppard, RPh is a Corporate Trainer with the Eckerd Corporation.

The NCAP Technician Review Seminar includes: • preparation for exam day • pharmacy law • basic math • dispensing calculations • hospital calculations • commercial calculations • hospital practice review • a review of the top 200 most widely used drugs including side effects, interactions and counseling tips

NCAP TECHNICIAN REVIEW SEMINAR REGISTRATION FORM

Please REGISTER AT LEAST 7 DAYS PRIOR TO THE PROGRAM you wish to attend or CALL FOR AVAILABILITY.

Mail registration to:
NCAP, 109 Church Street, Chapel Hill, NC 27516
or fax registration to: 919-968-9430

The review will be held from **9:00 am to 6:00 pm** with a one-hour break for lunch (on your own). Please bring a calculator and a pencil.

Check the location and date you plan to attend:

❒ **June 15, Fayetteville**, Health Tech Center Auditorium, Rm. 111

❒ **June 29, Durham**, Glaxo Wellcome Tech Center, Rm. 911

❒ **June 30, Greensboro**, Moses Cone Hospital AHEC, Rm. 1040

❒ **July 13, Asheville**, Ashville-Buncombe Tech, Simpson Lecture Hall

❒ **July 14, Charlotte,** Mercy Hospital Auditorium

If required enrollment is not met, programs will be shifted to the next closest site. For more information or directions to meeting sites call NCAP at 919-967-2237, ext. 22 or visit www.ncpharmacists.org

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❒ Check here if you are a CPhT attending for 7 hrs. of CE credit.

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Are you a member of NCAP? ❒ Yes ❒ No

Cost including Exam Review Workbook: $55

Payment method: ❒ Check enclosed ❒ Visa ❒ Mastercard

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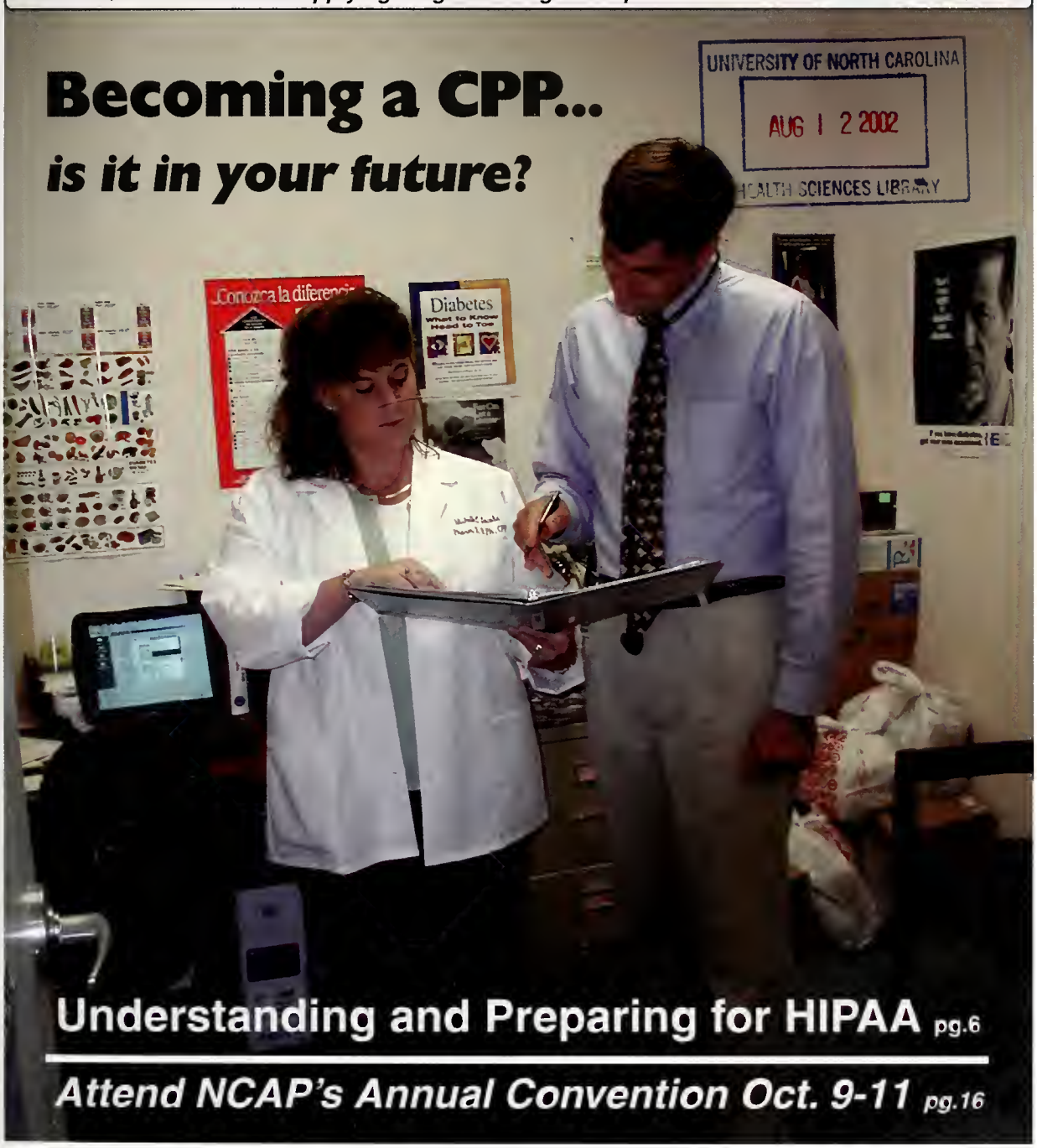
North Carolina Pharmacist

Volume 82, Number 3 ...applying drug knowledge to improve health Summer, 2002

Becoming a CPP...
is it in your future?



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North Carolina Pharmacist

Volume 82, Number 3 ...*applying drug knowledge to improve health* Summer, 2002

On the Cover...

Michelle Childs Jacobs, PharmD, CPP, RPh, Director of the Diabetes Care and Risk Reduction Program at the Open Door Clinic of Raleigh, reviews patient charts with Michael Casey, MD. Michelle is also a Clinical Pharmacist and Residency Director at Ward Drug in Nashville, NC.

Cover Photo by George Rideout

Inside

Fred Eckel
Executive Director

The State of North Carolina Pharmacy

I have finished my first year as NCAP Executive Director. It is time to report our progress to the members. NCAP is rebounding. We finished 2001 in the black, the first time in many years (when including NCPhA) that we finished in the black without requesting a grant from the Endowment Fund. A major reason for this is that we did not have to pay the Executive Director a market-based salary. We are on track to end this year with a surplus of almost $60,000, suggesting that within a year we will be back in the position to hire an Executive Director.

Our membership this year has increased by 150, although our total membership still accounts for less than 25% of North Carolina licensed pharmacists. Our Spring Meeting attracted more pharmacists than recent meetings. If our Fall Convention, October 9-11 in Greensboro, is as large as last year we will have another successful year.

A look at the North Carolina legislative arena suggests that pharmacy continues the battle to be heard and supported. The pharmacy business entities have elected to take responsibility for their own lobbying efforts. The North Carolina chain pharmacy group continues to work through the North Carolina Retail Merchants Association. Independent pharmacy owners have formed the Association of Community Pharmacy and hired their own lobbyist. The long-term care pharmacy corporations have retained their lobbyist as well. These groups have taken the lead on legislative initiatives, allowing NCAP to take a collaborative and supporting role but to reduce our lobbying expense. Right now we are many voices with one vision, but our victories are scarce and limited. I continue to feel that we will not be successful until we change our vision and our message, although I realize that there is no guarantee that a new message will result in a different outcome.

My concern is whether we can keep an alignment between pharmacy's business interests and pharmacy's professional interests. If these interests become different, who will be promoting pharmacists' professional interests? For sure we will need a stronger pharmacy organization. I continue to be committed to put NCAP in that position, but we will need increased membership for that to happen or else we will need to reduce our programs to support our resources.

Although there are many difficulties facing pharmacy, it is also a very exciting time as reflected by the articles in this issue on Clinical Pharmacist Practitioners. Although we hope that more pharmacists will become CPP's to demonstrate the viability of this role, the acceptance of the CPP so far has been outstanding. This is a viable role for pharmacists who want to have direct patient care. This is certainly one vision for pharmacy's future. Working with the NCAP CPP Committee, we will be putting CPP application information and copies of approved protocols on NCAP's web site to make it easier for pharmacists to complete the application. If you are engaged in drug therapy management I would hope you would consider becoming a CPP, even if your job does not require it. The more CPP's we have, the more accepted this role will become and the easier it will be to improve the rules and legislation. Current CPP's represent a cross section of pharmacists so any pharmacist in most practice settings can become one. I hope becoming a CPP is in your future.

North Carolina Association of Pharmacists
109 Church Street
Chapel Hill, NC 27516
phone: 919.967.2237 • fax: 919.968.9430

How Pharmacists Can Think About Professional Practice Opportunities

Ross Brickley
President

Dear Members,

Some pharmacists fail to do strategic planning. They miss opportunities to assess and measure if they are doing the "right thing." Our strategic planning should ask the following questions:

(A) How do patients see us?
(B) What must we excel at?
(C) How can we continue to improve clinically and create patient value?

The nation's healthcare system is not prepared to care for the increasing number of aging Americans. Now that the overall American economy is in recession, State and Federal Government Agencies are taking a hard look at the tradeoffs between short-term cost-saving maneuvers and long-term growth of Medicaid and Medicare eligibles.

Pharmacists sometimes make decisions based on an old set of assumptions. We sometimes don't really know what the key drivers of the non-financial area of our business are, nor do we understand how these areas relate to our patient's value.

We are entering an era in which the overwhelming focus of healthcare will be on treating the diseases of the patients, yet many pharmacists could do more to improve their clinical skills that will allow them to do their jobs more effectively.

Recognizing these trends, NCAP is focusing its efforts on strengthening its voice for pharmacy in N.C. Medications are a central, important aspect of the care of patients. Multiple providers, acute hospitalizations and OTC preparations can all contribute to complicating the drug regimen of a patient. Pharmacists are in a unique position to assess the safety and efficacy of their medication therapy and to determine whether it may have caused unacceptable adverse effects.

An additional area for pharmacists to think about is the under-utilization of necessary medications to treat conditions. Such underuse has joined overuse and misuse as indicators assessing the prescribing of medications to patients. Comprehensive programs to measure the quality of medication use in patients should evaluate both of these domains to provide the most thorough measure of the appropriateness of drug use in our patients that we serve.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), in general, requires patient authorization for the use or disclosure of private health information. David Wood's article, on page 6, provides background information on how HIPAA may impact pharmacists in their provision of pharmaceutical care. NCAP is supporting the development of a web-based HIPAA education/compliance program for our members. In addition, NCAP has endorsed a service provider who can help you become HIPAA compliant.

In closing, medication use provides an ideal opportunity for monitoring the quality of care in our patients. Unlike many other healthcare interventions, the evidence base for medication use is often clearly defined. Therefore, strategy-focused pharmacists are in a position to improve health outcomes and be compensated for impacting their patients' lives.

Sincerely,
Ross Brickley, RPh, MBA, CGP

...applying drug knowledge to improve health

Preparing for HIPAA

What Impact will the Health Insurance Portability and Accountability Act Have on You?

The Health Insurance Portability and Accountability Act (HIPAA) of 1996 helped Americans keep their health insurance through various life changes. This "portability" facet of the law was the first part of the legislation to be enacted. A timetable has now been established to implement the "accountability" facet, which will impact the use of protected health information. It requires, among other things, that the Department of Health and Human Services establish national standards for electronic health care transmissions and code sets. The need for this legislation was supported by congressional hearings related to incidents of disclosure of protected health information. There has been a great deal of public comment to Congress, as well as input from health care professionals. Sanctions, imposed by Congress, described by some as "Draconian," include fines in the hundreds of thousands of dollars and federal imprisonment for intentional disclosures. Enforcement by regulatory bodies will be bolstered by opportunities for "whistle blowers" to report non-compliant employers or irate patients seeking damages.

by David Wood

This article addresses the pharmacists' need to become aware of the intent of HIPAA with regard to electronic data transmission and to provide information to facilitate timely compliance. Pharmacists who have heard of HIPAA have focused on Title 11, Subtitle F, Administrative Simplification, dealing with the electronic exchange of health care data. Even though it's the center of the storm, there is much more to this legislation that deserves our full attention.

Behind the "dust up" of controversy over this part of the law, there lies the elements of privacy and security of all health information. There are limitations, faced by the pharmacist, in dealing with the former, but a proactive approach to protecting the privacy and security of all forms of protected health information will save time and money. A significant portion of this article will address the need to safeguard information from breaches of confidentiality, as well as physical loss.

Administrative Simplification

Electronic Transmission: The submission of claims is greatly impeded by the fact that there are approximately 400 formats for transmission. Although a pharmacist may rely on a clearinghouse or a software vendor to assist in this area, it is essential to understand the intention of the legislation. HIPAA gives the Department of Health and Human Services the authority to mandate the use of standards for the electronic exchange of protected health data; to specify the medical and administrative code sets to be used; to use national identification systems for patients, providers, health care plans, employers, payers and to specify the types of measures used to protect the security and privacy of personally identifiable health care information. Covered transactions include health claims, enrollment and disenrollment, eligibility, payment and remittance, claim status, premium payments, coordination of benefits, referral certification and authorization. Services affected include retail and professional pharmacy claims, as well as institutional and dental claims.

It is obvious that HIPAA will encourage the computerization of protected health information, but the benefits for the individual pharmacist may be harder to realize. Whatever costs absorbed in the Y2K transition will be multiplied when compared to HIPAA compliance. The long-term benefits of standardization will include lower operating costs and shorter receivables cycle. The difficulty in achieving standardization has been acknowledged by the availability of an extension for electronic transmission granted by Health and Human Services. Once obtained, the deadline then becomes October 16, 2003. It is vital that the application for extension be filed prior to October 16, 2002. The form is available now through the following website: www.cms.hhs.gov/hipaa/hipaa2/ASCAForm.asp. For additional information on HIPAA as it affects electronic submission in the pharmacy industry, see www.ncpd.org/news hipaa.asp. For information on the Designated Standards Maintenance Organization see http://www.hipa-dsmo.org/.

Privacy: With the regulation status now changed for transaction and code sets, some pharmacists have breathed a sigh of relief. However, the next targeted compliance is the privacy facet scheduled for April 14, 2003. Unlike transactions and code sets where clearinghouses and software vendors are key players, privacy procedures fall heavily upon the individual provider. The intention of the law in this area is to afford protection to patient confidentiality. Specifically, any information that identifies a patient with detailed health information is referred to as PHI, Protected Health Information. Where computerized data offers risks for massive intentional disclosures, PHI in written, auditory and visual form is highly vulnerable to unintentional disclosure.

The pharmacist is at the center of paperwork, phone calls, facsimiles and verbal consultations that risk disclosure. Measures to safeguard the various formats of PHI must be created through a process of risk analysis and mitigation. A search for specific regulations and standards within the law will prove frustrating. The absence of detail must not lull the provider into complacency, because the confidentiality facet of HIPAA presents the greatest risk of sanctions.

Although there are consequences of disclosure, as mentioned earlier in this article, and the Office of Civil Rights has also been tasked with enforcement, the most severe actions are expected to result from "whistle blowers," irate customers and disgruntled employees. Efforts toward compromise have produced the following results. The law expects, only, that the provider make "reasonable" and "cost effective" provisions to safeguard PHI. It is vital to remember that HIPAA will not give you technical guidance in the confidentiality facet. The compliance effort in this area will be 80% organizational and 20% technical.

Responsibility to become compliant begins with the top level of management regardless of the size of the organization. A privacy officer must be appointed and in smaller practices the individual will be the pharmacist. The privacy officer will undertake the study of the content of the legislation. The completion of the study must be verifiable, and the result of the study will be the creation of policy statements describing the measures taken to safeguard PHI.

As you know, malpractice is based upon breaches of protocol, but HIPAA prosecutions are based upon breaches of policy and procedure. Guidance in policy writing is widely available, but so general in nature it is of little value to the pharmacy privacy officer. While curriculum is currently being written, the most expedient approach is to conduct a risk analysis. This detailed examination of possible areas of disclosure is mandated by HIPAA and will also serve to target key elements in writing policy and procedure documents. Once risks have been identified, efforts to mitigate the risks can then be evaluated.

Each risk mitigation measure should be weighed against the cost of its implementation. The "reasonable" and "cost effective" provision will favor the independent pharmacist with limited resources. When the risk is, for example, auditory disclosure due to limited space, it is unreasonable to construct a consultation room at a cost of $25,000 to address the low risk of an unintentional disclosure. However, it is incumbent upon the privacy officer to show that such measures are considered, evaluated and documented. Other high-risk areas include methods for destruction of documents that have exceeded retention schedules. One high profile example was the recent Arthur Anderson case. Documents should be destroyed in specific ways and certificates of destruction must be obtained.

Security: The same methodology should be used when working toward compliance with the third element of HIPAA, the Security facet. Documents, identifiable media and data back ups must be protected from loss due to disaster, theft, deterioration or the technical obsolescence of retrieval systems. Environmental concerns for paper and other media include humidity, heat rate rise and acidity. Storage areas should conform to standards published by state archivists. In a case where the pharmacist keeps paper records in the garage, basement or attic, the "reasonable" aspect of HIPAA will favor flexibility in areas where there are no commercial records centers. The reason for such an exception is that the security provision also requires uninhibited retrieval of the PHI. Sources for additional information on security include the Association for Image and Information Management and the Association of Records Managers and Administrators.

A final element of HIPAA compliance is the need to secure business associate agreements with individuals and organizations that come into contact with protected health information. The pharmacist's liability extends through the "flow" of the PHI as well as the chain of custody. The Business Associate Agreement is an important tool to protect the pharmacist from disclosures by documenting procedures established by those who provide products and services to the pharmacies. These include clearinghouses, software vendors, pharmaceutical reps, building maintenance and dozens of others who can access PHI.

All the elements discussed, outside the electronic transmission facet, are relatively simple to audit and mitigate. The burden becomes the documentation of training and the composition of all required policy documents. In some cases, as many as 26 policies must be written at an average of seven pages each per policy document. Outside resources for compliance assistance are not as readily available as, for example, OHSA compliance services. This is due to the variations in how PHI is formatted, handled, stored, retrieved and transmitted. Organizations such as NCAP are working to provide access to resources for comprehensive training and time saving documentation templates for the pharmacy industry. With help in risk analysis, mitigation and documentation the task of HIPAA compliance in confidentiality and security will become very manageable. It is essential to remember that work in these two facets can and should be initiated without delay. Legislative changes and technical issues must not hinder the pharmacists in any needed organizational changes to protect health care information from loss or disclosure.❖

The difficulty in achieving standardization has been acknowledged by the availability of an extension for electronic transmission granted by Health and Human Services. Once obtained, the deadline then becomes October 16, 2003. It is vital that the application for extension be filed prior to October 16, 2002.

About the Author...

David Wood has held various positions with leading companies in the records management industry, including 3M Company, Xerox and has served as Vice President for Product Development with Starpoint Global Services headquarted in Chapel Hill, NC. He has published articles in the professional journals of ARMA, AIIM, and NAVA as well as producing documentaries for Iowa Public Television. Trained as an educator, Mr. Wood completed undergraduate and graduate course work at East Tennessee State University. Certification for Records Management was earned through the ARMA chapter at the University of Georgia. Preparation for HIPAA compliance began through study under the Law Firm of Tomes and Dvorak in Overland Park, Kansas. He recently completed additional work through the Health Information Management SHARP Workgroup and curriculum sponsored by the American Accreditation HealthCare Commission.

Becoming a Clinical Pharmacist Practitioner...

by Betty Dennis

The Clinical Pharmacist Practitioner Act became effective July 1, 2000. This legislation acknowledged the need for Clinical Pharmacist Practitioners and the importance of collaborative practice. The successful implementation of the Act resulted from the dedicated efforts of many pharmacists and physicians, including members of a subcommittee that was appointed in 1999 to promote this initiative. Committee members included Ken Chambers, MD, John Dees, MD, John Foust, MD, and Stephen Herring, MD representing the Medical Board. Albert Lockamy, Robert Crocker, and Jack Watts represented the Pharmacy Board. Other members of the committee included Dan Garrett (Executive Director of NCPhA), David Work (Executive Director, Board of Pharmacy), Denise Stanford (attorney, Board of Pharmacy), Diane Meelheim (Medical Board), and Jim Wilson (attorney, Medical Board). Rules were developed by the North Carolina Boards of Pharmacy and Medicine and these became effective April 2001 (21 NCAC 46.3101).

As of June 2002, there have been 34 Clinical Pharmacist Practitioners (CPPs) approved by both the Boards of Pharmacy and Medicine. The application process includes documentation of credentials, practice experience, collaborative practice policies and protocols, signature of supervising physician, and a $100 fee payable to the Medical Board. The Board of Pharmacy reviews applications during monthly meetings (odd numbered months) and forwards the approvals to the Medical Board for review the next month (even numbered months). The Medical Board issues the CPP registration number and is responsible for the annual renewal process that requires 35 hours of continuing education and a renewal fee of $50.

The credentials required for CPP registration were developed after discussion and input from many sources, including the North Carolina Center for Pharmaceutical Care (NCCPC). Requirements include a North Carolina pharmacist license, agreement with supervising physician and:

- certification (BCPS, CGP) or ASHP Residency including two years clinical experience or …
- PharmD degree with three years experience, plus completion of one NCCPC or ACPE Certificate Program or…
- BS degree with five years experience, plus completion of two certificate programs.

A Clinical Pharmacist Practitioner is defined as a "licensed pharmacist in good standing who is approved to provide drug therapy management under the direction of, or under the supervision of, a licensed physician who has provided written instructions for a patient and disease specific drug therapy which may include ordering, changing, substituting therapies or ordering tests." The Supervising Physician is held accountable for on-going supervision and evaluation of the drug therapy management performed by the CPP as defined in the physician, patient, pharmacist and disease specific written agreement that is submitted with the CPP application.

The drug therapy management protocols that are developed for the collaborative practice need to be specific in regards to the physician, pharmacist, patient and disease. The agreement must include the diagnosis and product selection by the physician and any modifications which may be permitted, dosage forms, dosage schedules and tests which may be ordered. Many CPP's have met these requirements by including specific protocols and algorithms for a specific service, such as anticoagulant monitoring. The protocols are somewhat broad and generalized to allow maximum patient specific therapy. The diagnosis of the patient is confirmed when the physician "refers" a patient to the CPP practice for specific drug therapy management services that are outlined in the protocols, and this diagnosis should be documented by the physician and the CPP. The requirement for product selection by the physician has been interpreted to be met when the physician "refers" a patient with a specific diagnosis to the CPP practice to be managed per the approved protocol(s). It is essential that the CPP develop a system of documentation for all patient assessment, education and drug therapy management.

In addition to the above, the written agreement with the

CPP's in North Carolina as of June, 2002:

Randal Von Seggern	**Patsy Huff**
Bryan Bray	John Nance
Stephanie McClain	**Rebekah Satko**
Brian Peek	**Frances Whaley**
Mary Bryant	**Tina Brock**
Beth DeWitt	**Robert Crouch**
Anna Garrett	**Jacquelin Harrell**
Terry Laws	Elizabeth Michalets
Robert Malone	**Catherine Miller**
Michelle Childs Jacobs	**Mollie Scott**
Brian Peek	Gwen Swenberg
Charles Sprinkle	Angela Pentecost
Betty Dennis	Barbara Kostic
Wendy Everhart	**Vickie Ripley**
Christine Goodman	**Dawn Cender**
John Grinder	Kimberly Gwinn
Jennifer Hamilton	**Nancy Hardie**

**** Names in bold type indicate NCAP members.***

...is it in your future?

Supervising Physician must include a plan for weekly quality control, review, and countersignature of orders in a face-to-face conference between the Supervising MD and the CPP. It is required that all patients be notified of the collaborative relationship. Additional details concerning the CPP requirements are available on the Board of Pharmacy web site at www.ncbop.org.

NCAP has appointed a CPP Committee to promote and support CPP practice. Goals of the Committee are to: (1) promote and encourage pharmacists to become CPP's, (2) identify ways NCAP can support needs of current CPP's, and (3) recommend policy to the NCAP Board and House of Delegates that will further the pharmacist's role in direct patient care.

In March 2002, the NCAP CPP Committee developed a survey to assess current CPP practice. The survey was mailed to the 28 CPP's who had been approved to practice, and 23 surveys (82.1%) were returned for evaluation. Data indicate that 16 CPP's currently bill for their patient care services and 18 have agreed to have a summary of their practice included on the NCAP Web site as a resource for others who are interested in developing a CPP practice.

Of the 23 survey responders, seven CPP's practice in a physician's office, six in a hospital clinic, two in a long-term care practice, with the majority practicing in ambulatory care settings. The most common credentials for CPP approval include the BS in Pharmacy degree with five years of clinical experience and completion of two approved certificate programs. Seventeen CPP's have earned the PharmD degree and nine have completed residencies.

The most common drug therapy management services provided by surveyed CPP's are for patients with diabetes, asthma, hypertension, hyperlipidemia, heart failure, anticoagulation, and pain management. Other services include protocols for smoking cessation, epilepsy, polypharmacy, COPD, osteoporosis, obesity, infectious diseases and renal disease.

Successes described by CPP's in practice include improved patient care outcomes, reimbursement for patient care services, enhanced efficiency of practice, improved continuity of care, creation of a model of practice for students and residents, recognition by physicians for patient care services, increased scope of practice and increased career opportunities. The enthusiasm of one CPP is indicated by a comment on the survey that states: "It's the most rewarding thing I've ever done professionally."

The primary barrier to CPP practice was identified as the requirement for the CPP practice to be physician-pharmacist specific, when many medical practices include multiple physicians. An interpretation of this requirement by the Board of Pharmacy has allowed a referral type practice for these sites. Physicians in a group practice can "refer" patients to the CPP collaborative practice with Supervising Physician, and then the patient can be managed per the approved disease management protocols. This referral type practice is common in healthcare and offers an option for pharmacists who work with multiple physicians. The Supervising Physician is still accountable for all drug therapy management services provided by the CPP and must agree to the specific plan of any collaborative practice.

Other barriers to CPP practice were the cost, CE requirements for annual renewal, and credentialing by the practice site or healthcare system. Challenges include clarification of insurance and billing for patient care services, gaining recognition as a healthcare provider and reimbursement for patient care by Medicare, and obtaining DEA numbers that are especially important for CPPs providing pain management services. Documentation, paperwork, and work overload were listed as daily challenges in practice.

Several suggestions are recommended to facilitate the CPP application process. It is helpful to include a cover letter with a general summary statement of the practice. Also include a statement that indicates support for the CPP application such as

Clinic Director, Director of Pharmacy, P&T Committee, and Supervising Physician and copy appropriate individuals on the letter. Development of a "Scope of Practice Statement" is suggested to focus the vision and mission of the practice. Policies and procedures should include documentation and database management. Protocols for drug therapy management should be evidence-based and include provisions for management of acute exacerbations of disease.

The Clinical Pharmacist Practitioner Act opened the door for collaborative practice opportunities. Pharmacists are encouraged to contact their congressmen concerning legislative bills that are being considered by Congress that would enable pharmacists to be paid for cognitive and medication management services. The Medicare Pharmacist Services Coverage Act (S 974, HR 2799) proposes to amend the Social Security Act to recognize pharmacists as healthcare providers. Passage of this Act would enable pharmacists to bill for patient care and medication management services provided to Medicare beneficiaries. Another bill, The Medicare Drug and Service Coverage Act of 2002 (HR 3626 MEDS Act), provides a Medicare outpatient prescription-drug benefit that would pay for pharmacists' medication-management services. It is essential that pharmacists be proactive in these initiatives to promote pharmaceutical care services. Contact your senators and members of Congress today (www.congress.gov). The process is very easy, it does not take much time, and it is VERY important that we speak out for the future of our profession.

The question has been asked, "Why should I become a CPP" when I have been providing patient care services for years. Although there are many possible responses, there is agreement by many that establishment of an approved CPP practice is an investment in the future of our profession that will benefit generations of pharmacists and patients. The practice can demonstrate a model for students that can be adapted to many environments, improve patient care outcomes, and increase patient awareness of the availability of pharmaceutical care services. The CPP initiative began as a vision. It was created with the philosophy of patient focused pharmaceutical care. It is the responsibility of practitioners to make it a reality for pharmacy practice.

About the Author...
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Bryan Bray, CPP

I currently practice as a Clinical Pharmacist Practitioner in a multi-specialty physician practice, which includes Internal Medicine, Cardiology, Endocrinology, Geriatrics, Hematology/Oncology, Rheumatology and Gastroenterology. I am also a provider in the Piedmont Pharmaceutical Care Network as well as a clinical manager and consultant pharmacist for PharMerica, which provides services to long-term care facilities. I will focus most of my practice profile on the physician office-based part of my practice.

I currently provide consultative services in the physician's office in anticoagulation, diabetes, hyperlipidemia, hypertension, asthma, COPD, osteoporosis, CHF and polypharmacy/general pharmacotherapy. I really believe it is important to work collaboratively with physicians, while showing them you have expertise in managing medications. I have been providing services in the physician-office practice for four years. Patients are referred to me via their attending physician. The patients will then schedule an office visit with me. During this office visit I collect a history, perform physical assessment, provide individualised education, order tests, interpret tests and initiate/adjust medications. The biggest impact I have made on the practice has been, in addition to patient education, pharmacotherapy management services. Patients with chronic diseases are unique in that they often have several comorbidities and they often are on multiple, complex medications. This makes the visits with their physician very complicated as he/she has to deal with multiple issues in a 15-20 minute office visit. My collaboration with the physicians on these chronic disease cases help maximize pharmacotherapeutic interventions in terms of efficacy and minimize cost as well as adverse reactions/toxicity. The physicians commonly refer their most difficult to manage patients to my service. Although I had been providing services well before the legislative changes, the enactment of the CPP legitimized my ability to manage medications and solidified my qualifications in the mind of the physician providers within the practice. My protocols tend to be open-ended in terms of ordering medications and tests as the physicians very closely supervise my visits with the patients. I often discuss the patient with the physician prior to my decision-making and sometimes the physician will have some face-to-face time with the patient as well. Becoming a CPP allowed me to write prescriptions and order tests without having the physician sign off on the order prior to it being acted upon. I currently receive reimbursement via the "incident-to" guidelines. I am a contracted employee of the practice and I work under a supervising physician every day. My contractual arrangement allows me to bill the practice hourly for my services while providing incentives for higher production. I also have a certified medical assistant who assists me in order to make my visits more efficient. I believe the CPP legislation will allow for pharmacists to gain independent provider status, much the same way nurse practitioners do today.

by Bryan Bray

I believe the biggest obstacles to a pharmacist becoming licensed as a CPP are a lack of physician awareness of the benefits of the collaborative relationship, lack of solid reimbursement procedures, lack of pharmacist understanding of how the CPP legislation may actually help lead to independent provider status, and current work-environment pressures to continue to fill prescriptions as opposed to stepping outside the box to provide non-traditional services. Again, I stress it is very important to develop a collaborative role with the physicians as many of them have a perception that the services we offer are competitive with their own for the health care dollars. In many cases, I have picked up on significant new medical problems and been able to refer patients back to their primary physician or specialist to be treated. I also focus on providing a quality check to assure patients are up to date with vaccines and other preventative medicine measures (i.e. ETT's for patients at high risk, EKG's, dental exams, Oph. exams, etc.). It is very important that the CPP collect outcomes data to prove to the physicians how your services are enhancing the quality of medical care while improving their individual profitability as well as the practice's profitability as a whole. I currently use diabetes tracking software to track A1C's, BP's, Lipids, medications, urine for microalbumin and other parameters as well as anticoagulation software to track INR's in/out of range as well as therapeutic/ADR outcomes to track clinical measures.

Another interesting area of practice I am involved in is being a provider with Piedmont Pharmaceutical Care Network. Currently I am providing anticoagulation management services for outpatients who are status post joint replacement and receiving reimbursement for my services. I am also conducting several polypharmacy projects for both community-dwelling and institutionalized geriatric patients. I believe that this area of practice will begin to grow immensely. I am certified to provide diabetes, lipid, hypertension and asthma management for the network.

I strongly believe our state association should provide support to overcome the above obstacles to advance the licensing of CPP's. A particular area of importance is the support of legislation that will allow pharmacists to gain credentials as health care providers under the Social Security Act. I truly believe I have been blessed with the opportunity and management support to become directly involved with patients and physicians, one on one, to improve medication use. I hope to see more and more pharmacists adopting this type of practice in the future.

About the Author...
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Anna D. Garrett, CPP

Cornerstone Health Care is an integrated multispecialty physician group located throughout High Point, NC and surrounding communities. It is composed of approximately 80 providers, 24 separate practices and a wide range of ancillary services such as imaging and laboratory services. It is one of the largest employers in High Point and has developed the reputation of being very progressive in the delivery of quality health care.

In March of 2001, the Medical Director of Outpatient Laboratory Services approached me about the possibility of developing a medication management program for the Cornerstone physicians. We chose anticoagulation as the initial service because we knew that patient management could be improved by creating a centralized clinic devoted to anticoagulation. Also, a large amount of physician and nurse time was consumed calling patients to adjust warfarin doses so we knew practice efficiency could be improved. The service is also billable under Medicare incident-to rules. Over the next year, protocols were developed for managing the service and a location for the office was identified. I applied for, and was granted, Clinical Pharmacist Practitioner (CPP) status in July, 2001. Several representatives of Cornerstone attended the NCAP CPP seminar in August of 2001. The proposal for the service was presented to, and approved by, the Cornerstone Board of Directors as a one-year pilot program in October, 2001.

by Anna D. Garrett

I began work as a Cornerstone employee in March, 2002. I have a contractual relationship similar to other Cornerstone providers. The service is set up as a referral service that can be used by any physician in High Point. Currently, more than 95% of my patients are referred to me from within the Cornerstone system. Patients are referred to one of my supervising physicians who then refers them to me. The rationale for this model is minimization of the number of CPP protocols needed for the practice.

The practice is located in the rear of one of our outpatient laboratories where phlebotomy services are available. My supervising physicians are located in an internal medicine practice adjacent to my office. I currently see about 350 patients and continue to get new referrals weekly. Vascular surgeons and internal medicine physicians refer the majority of my patients. In addition to warfarin management, I provide outpatient deep vein thrombosis (DVT) treatment. I teach injection technique for enoxaparin, and initiate and monitor warfarin therapy. We are currently exploring options for drug therapy management services for other disease states.

Reimbursement for my services is obtained using indicent-to billing rules. The internal medicine practice next door manages the billing and appointment systems and provides clerical support for the practice. Cornerstone management expects the service to at least break even in the first year. The billing and documentation issues have been the most difficult part of the learning experience. I have been fortunate to have a billing consultant who works for an accounting firm available to me from the inception of the service. She is an expert in the nuances of the Medicare billing system. I would advise anyone who is considering this type of practice to make the investment in a consultation with this type of person. There are many situations that may allow for a higher level of billing than pharmacists typically believe they are able to do.

My interest in becoming a CPP arose largely because I wanted to become more involved in direct patient care. My first experience with this type of practice was in the HIV Clinic at Baptist Hospital. When the opportunity for my current practice came about, I realized that it would go much more smoothly if I were able to write my own prescriptions and practice in a fairly autonomous manner. However, if the project had failed to materialize, I had hoped that I would be able to use it in my role as an inpatient pharmacist.

Many pharmacists think obtaining the CPP credential is difficult. My perspective is that there are really only two things that must happen for one to successfully become a CPP. The first part of obtaining the CPP credential is having a strong collegial relationship with a physician in your community who is willing to assist with protocol development and serve as a supervising physician. The Medical Director of the outpatient laboratory is an oncologist with whom I had worked at High Point Hospital. He wanted me in this role because he knew I was interested in working directly with patients and would do whatever it took to make the project a success. The second part of becoming a CPP is meeting the qualifications stipulated by the Boards of Medicine and Pharmacy. There are several ways to meet these qualifications. I was able to qualify based on my past experience and BCPS certification. My general background in clinical practice allowed me to learn what was needed for anticoagulation management. I also took advantage of resources available from some of the national pharmacy organizations.

I would encourage anyone who is interested in direct patient care to become a CPP. I believe having pharmacists in this role will advance the public and medical profession's perceptions of the clinical role of pharmacists. It also lays the groundwork for further recognition of pharmacists by payers. I have heard comments from older pharmacists that they do not feel prepared for this role. Younger pharmacists do have the advantage of being taught "pharmaceutical care" in pharmacy school, but all of us are capable of providing it. All it takes is a desire to improve your patients' lives. It is the most rewarding work I have ever done.

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Randal Von Seggern, CPP

The road to Clinical Pharmacist Practioner (CPP) started for me in 1994 when I joined the practice of James U. Adelman, MD at the Adelman Headache Center in Greensboro, NC. Dr. Adelman was one of the first physicians to recognize the value of having a pharmacologist in a medical office. Having an expert on medications manage patients' drug therapy and serve as a resource to him and the nursing staff was a logical addition to his office. I also was charged with developing a research program in the office, since clinical trial sites were, and are, moving toward private practice.

Dr. Adelman and I also believed that it made no sense to have a professional with advanced training in medications not be able to prescribe medications. In an effort to educate the medical community on the concept of utilizing a PharmD in a medical office, and to put forth the concept of a CPP, we published an article in 1995 in the *North Carolina Medical Journal*[1]. This article described our practice and compared the educational background of physician assistants, nurse practioners and PharmD's. We argued that if PA's and NP's are adequately trained to have prescribing privileges it is only logical to give those same prescribing privileges to a clinical pharmacist who is in collaborative practice with a physician. Dr. Adelman continued to take our argument to the NC Medical Board and was key in persuading them to accept the concept of the CPP. It has always been my belief that we cannot control our profession if we have no control over our product (medications). In order for clinical pharmacists to maximize our effectiveness, we must be able to manage drug therapy and order appropriate laboratory tests to properly monitor effectiveness and safety. The CPP license has allowed me to more efficiently manage my patients' drug therapy.

by Randal L. Von Seggern

Over the years my practice has evolved into a combination of patient care and drug research. We are a headache center, so I specialize in managing drug therapy for patients suffering from headaches. Patients are referred to me by Dr. Adelman or one of the other neurologists in our practice. Patients come to me on therapy initially started by the physician. I then change dosing, discontinue, and start medications depending on how patients are responding and tolerating their therapy. I also order appropriate laboratory tests to monitor patients' drug therapy and advise them on OTC medications and non-drug therapies. One of the most rewarding aspects of private practice is being able to manage your patients on an ongoing basis. Incorporating non-drug therapies into treatment plans allows one to provide the type of comprehensive therapy we were taught in our PharmD programs.

I subsequently formed my own company/practice, PharmQuest. I contract with Dr. Adelman to see patients he refers to me and to collaborate in conducting headache studies. I also collaborate with other physicians in the Greensboro community to conduct pharmaceutical company sponsored clinical trials.

Reimbursement is critical to the long-term survival of the CPP. After consulting with the insurance carriers and managed care companies, we have always billed my services through Dr. Adelman's provider number. I typically bill at a revisit level three or four. My patient encounter forms are different from the physicians. The form allows me to document the complexity of decision making, patient education performed and time spent with the patient. Revenue generated from research has been critical in covering my salary, as well as contributing to the cost of operating our office. CPP's will be much more attractive to a medical office if they not only cover their salary, but help pay expenses and generate a profit for the practice.

The CPP is the leap forward in clinical pharmacy that many of us have been waiting years to see. It provides clinical pharmacists the opportunity to effectively collaborate with physicians and utilize all the years of clinical training and experience we have accumulated. It provides the opportunity to better demonstrate our skills to the public. Once a broader base of patients understands the services CPP's can provide, we can expect public demand for our expertise. One of the most rewarding aspects of my practice is the positive patient response to my services. Patients strongly support a pharmacologist managing their medications and coordinating that care with other health care providers. It is not unusual to have patients requesting to see me on their next visit rather than one of our physicians, because they want the "drug expert" to review their medications. In this era of poly-pharmacy and specialized medicine, clinical pharmacy has a wonderful opportunity to play a more active role in clinical care. The CPP gives pharmacy a useful tool to step boldly in that direction.

Appropriately trained clinical pharmacists need to actively identify physicians in their area who are open-minded enough to listen to a presentation outlining the value of bringing a CPP into their practice. NCAP and present CPP's can provide support and advice on how to most effectively convince these physicians to bring a clinical pharmacist into their practice. The Clinical Pharmacist Practioner license presents pharmacy in North Carolina with a golden opportunity to advance patient care.

[1]Adelman JU, Von Seggern RL. Office Rx: A renewed professional relationship. NC Med J 1995;56:262-264.

About the Author...

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Pete Crouch, CPP

There have been many changes since I graduated from UNC in 1976 with a BS in Pharmacy. We used manual typewriters unless you were lucky enough to have an electric, and receipts were usually handwritten. Each time a prescription was filled the original had to be looked up, dated on the back and then filed away again. Soda fountains were more common so you usually had a place to eat lunch and chat with customers. Hospitals have changed also; they used computers but only for keeping track of a patient's bill. I remember sending a five-day supply of meds to patients because that was the average length of stay. One thing is for certain, things will never stay the same.

Since those days, I have worked in several community settings, a hospital, and a major chain store. I have to admit, my favorite is community pharmacy. In 1995, I was employed by Hospice of Rockingham County as a pharmacist consultant and to function as an active member of the interdisciplinary team. Today I continue working with Hospice but mainly practice pharmacy at Eden Drug, a traditional community pharmacy with a few exceptions. The store is located near a major highway in Eden, NC and averages 300+ prescriptions per day. We have three pharmacists and four full-time technicians of which two are nationally certified. There are two patient counseling areas, one for disease state management programs and another for stand-up counseling near the checkout. Eden Drug has delivery service, HME, and charge accounts. We are a member of PCCA with a compounding center and a laminar flow hood. I have recently received certification in compounding sterile products such as nebulizer solutions, IV meds, eye drops, etc. I have also completed several disease state management programs.

by Pete Crouch

I always thought that someday I would eventually earn my PharmD degree. When that didn't happen, I turned to the certificate programs. My first certifications were in Asthma and COPD. Later the next year, I became certified in Diabetes. As the CPP program evolved, I began thinking of how I could work with a physician in a collaborative setting. Since 1995 I have met weekly with pulminologist Ed Hawkins, MD, and other Hospice team members. We all work together in efforts to manage symptoms of terminally ill patients and to help them and their families work through complex end of life issues. Due to the long relationship between Dr. Hawkins and myself, I felt we could collaborate in other ways, and he agreed. We had other things in common as well: we are about the same age, both of us specialize in lung diseases and he was also a pharmacy graduate before entering medical school. My thoughts were to work in his office one day a week and help manage his asthma and COPD patients. We had two problems, a limited amount of office space and a conflict in our work schedules. The saying, "think outside the box," kept interrupting my thoughts. One day I received an email from NCAP promoting an immunization certificate program. At that time I started to explore the possibility of a collaborative practice outside the physician's office. An immunization program would compliment my other certifications and give patients easy access to preventative vaccines. I continuously reminded my asthma, COPD and diabetic patients to get flu and pneumonia shots because over 50,000 deaths occur annually from these diseases. Since North Carolina is not one of the 30 states that allow pharmacists to administer immunizations, the CPP credentials with protocols and standing orders from a physician would make everything legal.

The program was approved by Dr. Hawkins and then it was time to get to work. First I had to update my CPR certification and attend the immunization program. Protocols and standing orders had to be written for administering vaccines as well as management of severe allergic/anaphylactic reactions. The decision was made to immunize adults over 18 years of age and our protocols and standing orders allowed flu, pneumococcal, hepatitis, and tetanus, as well as travel vaccines to be administered. Next the CPP application had to be submitted to the Board of Pharmacy and then to the Medical Board for approval.

At last, the application was approved, flu and pneumococcal vaccines had been ordered, a date was set and a nurse was hired to help with the first round of immunizations. I then marketed the program, printed educational material and prepared two private areas to administer the vaccines.

As the program progressed, our billing specialist began to bill Medicare for all eligible patients. The Medicare roster billing ID number had been applied for and granted. Roster billing is a simplified billing procedure that allows a roster of patient names and their identifying information to be attached to one HCFA form. Approximately 75% of our patients had Medicare, the other 25% paid cash for their injections. Non-Medicare patients were charged $12.00 for the flu shot and $18.00 for the pneumonia shot. A total of 450 patients were immunized.

Pharmacists interested in becoming a CPP must first have a physician willing to work with them in a collaborative way. When a close professional relationship can be established, then becoming a CPP is a process of certificate programs, finding a professional service that is needed and then applying to the Board of Pharmacy and Medical Board for approval.

About the Author...

Pete Crouch, RPh, CPP works at Eden Drug in Eden, NC and can be reached via e-mail at pcrouch@vnet.net

NC Board of Pharmacy Elects New Representatives

NCAP members Betty Dennis (seated left) and Rebecca Chater (seated right) have been elected to serve on the North Carolina Board of Pharmacy. They took office in May and are the first two Pharmacy Board members who have earned advanced degrees. Betty represents the North Central region of the State and Rebecca represents Western North Carolina. Board of Pharmacy President Wallace Nelson (standing left) represents North Eastern North Carolina and Vice President Stan Haywood (standing right) represents the South Central region of the state.

American Society of Health-System Pharmacists Products Now Available Through NCAP

You can help NCAP while helping yourself become a better practitioner. NCAP is now an authorized agent for many ASHP products including books, subscriptions, videotapes and software. Any ASHP product ordered on the NCAP/ASHP order form will mean $$$ for NCAP but not increased cost for you. Hospital pharmacists, consider ordering your AHFS DI subscription through NCAP. The same quantity discounts will apply. For a list of products and an order form please visit www.ncpharmacists.org or call NCAP at 919-967-2237, ext. 26.

Don't Miss NCAP's Annual Convention

October 9–11, 2002, Sheraton Greensboro/Koury Convention Center

...applying drug knowledge to improve health

WEDNESDAY, OCTOBER 9

11am – 1 pm	Registration
11:30am – 1 pm	NC Board of Pharmacy Open Hearing
1pm – 4pm	CONCURRENT SESSIONS

A. Getting Started in Your Career (especially for residents, students, & young, in career, pharmacists)

1pm – 2pm	Speaking for Excellence (supported by Bayer) - Speaker TBA
2pm – 3pm	Selecting a Job or Starting Your Career – Fred Eckel & Jim McAllister
3pm– 4pm	Benefit Packages: What do I Need to Know? - Speaker TBA

B. Contemporary Pharmacotherapy for CNS Disorders

1pm – 2pm	Management of Depression – Lisa Jackson
2pm – 3pm	Novel Uses of Medications in Treating CNS Disorders - Speaker TBA
3pm – 4pm	Epilepsy Management– William Garnett

C. Current Issues in Antibiotic Pharmacotherapy

1pm – 2pm	Advances in Treatment of Invasive Fungal Infections – Speaker TBA
2pm – 3pm	Antibiotic Dosing Pharmacodynamics: New Ways to Give Old Drugs - Speaker TBA
3pm – 4pm	Pharmacy-Based Interventions to Improve Infectious Disease Treatment Outcomes - Speaker TBA
4pm – 6pm	Exhibits, Residency Showcase, & Reception

THURSDAY, OCTOBER 10

6:30am – 8am	Side Symposium I: *Men's Health* – Speaker(s) TBA
	Side Symposium II: *Women's Health* – Speaker(s) TBA
7am– 8am	Registration & Continental Breakfast
8am – 12pm	*Plenary Session: Improving drug therapy - the CERTS model*
8am– 8:30 am	What is the CERTs Program? – Speaker TBA
8:30 – 9:30 am	Improving Pediatric Drug Therapy: The UNC-CH CERTs' Program • An overview - Bill Campbell • Adverse Drug Events Project - Rowell Daniels • Otitis Media Project - Dale Christensen
9:30 –10:30am	Break & Exhibits
10:30 – 11:30 am	Improving Cardiovascular Drug Therapy: The Duke CERTs Program – Judy Kramer
11:30 am – 12 pm	What next for the CERTs? -Bill Campbell & Judy Kramer & a speaker TBA
12 – 2pm	Exhibits & Lunch
2pm – 4pm	CONCURRENT SESSIONS

A. Legal & Ethical Issues (Especially relevant to Pharmacy Technicians)

2pm – 3pm	Pharmacy Law & Rules Update – Jim Boyd
3pm – 4pm	What to do When a Medication Error Occurs - Jim Boyd

B. Rational vs Cost Effective Pharmacotherapy?

2pm – 2:40pm	For Arthritis – Mary Roth
2:40pm – 3:20pm	For Hypertension – Wayne Pittman
3:20pm – 4pm	For Acid-Peptic Disorders – William Garnett

C. Round Table Discussions (Rotate every 30 minutes between tables of your choice)

Table 1: Preventing Pediatric Adverse Drug Events - Rowell Daniels

Table 2: Improving Cardiovascular Drug Therapy – Nancy LaPointe
Table 3: Improving Drug Therapy for Otitis Media – Dale Christensen
Table 4: Improving Immunization Rates: Opportunity for pharmacists – Stefanie Ferreri
Table 5: The Clinical Pharmacist Practitioner & Reimbursement for Services – Speaker TBA
Table 6: Living with Drug Shortages – Jane Hughes
Table 7: Prescription Order Entry Technology in the Hospital – Leslie Mackowiak
Table 8: Automated Dispensing Systems: Pyxis®, etc., – Stephen Eckel

4pm – 5pm	NCAP Award Ceremony
5pm– 6pm	Reception in Honor of Awards Recipients & NCAP Officers
6:30 pm	Leadership Dinner & Entertainment

FRIDAY, OCTOBER 11

6:30 – 8am	Side Symposium III: *Dyslipidemia Pharmacotherapy Update*
7:30 – 8:30am	Registration & Continental Breakfast
8:30am – 12pm	CONCURRENT SESSIONS

A. Improving Disease Management: North Carolina Programs

8:30 – 9:30am	Medical Review of North Carolina Immunization Program – Speaker TBA
9:30 – 10:30am	North Carolina Asthma Initiatives – Roy Pleasants & Jerry Wiley
10:30 – 11am	Break
11am – 12pm	North Carolina Heart Disease And Stroke Prevention Task Force:"Start With Your Heart" – Libby Puckett

(Alternative for any of the above: The Asheville Project: An Update)

B. Legislative Update on National & North Carolina Pharmacy Issues

8:30 – 9:30am	National Legislative Issues – Ed Webb
9:30– 10:30am	North Carolina Board of Pharmacy Issues – David Work
10:30 – 11am	Break
11am – 12pm	State Legislative Issues, with Commentary on Survival in 2003! - Panel of Speakers TBA

C. Pharmacotherapy Updates

8:30 – 10am	Update on Heart Failure Therapies – JoEllen Rodgers & Speaker TBA
10am - 10:30am	Break
10:30 am – 12pm	Update on Anticoagulation Therapies: Focus on Direct Thrombin Inhibitors -Donald Harvey & Speaker TBA
12 – 12:30pm	Box Lunch
12:30 – 3pm	NCAP House of Delegates/Business Meeting

Money for Student Scholarships Sought

NCAP is offering $25 scholarships to cover the cost of registration fees for students who wish to attend the October Convention. If you would like to financially assist a student, please look for more information in the Convention brochure/registration form or call NCAP.

As Demands Increase on Technicians, So Should Salaries

by Joe Anne Griffith

As a pharmacist and a pharmacy technician educator, I am more than concerned about the low starting wages for technicians in our profession. According to the most recent edition of the *North Carolina Health Careers Manual*, published by our state's Area Health Education Centers, the average salary for a pharmacy technician is $18,500 a year. An annual salary of $18,500 is approximately $356 a week or $8.90 an hour. It is time for the profession of pharmacy to pay attention to these low hourly wages paid to pharmacy technicians. Yes, we must face the situation at point blank range. Pharmacy technicians are not justly compensated for the duties they are expected to perform. This average financial compensation does not afford a pharmacy technician to survive economically.

There is a chronic shortage of well-trained and educated pharmacy support personnel in our state. One way to attract people to our profession is to offer them a decent and fair wage. I do not believe that this is being done. When the shortage of pharmacists surfaced, the salaries certainly went up. Why isn't this the case for trained, educated and experienced technicians? Pharmacists say they want technicians to consider themselves professionals within our pharmacy settings. Practicing pharmacists say they want pharmacy technicians to view their employment as a career. I say pay them the wages they so honestly deserve.

It is essential for practicing community and institutional pharmacists to have competent technicians assisting them with the drug distribution processes for the delivery of pharmaceutical care to be successful.

I consider pharmacy technicians to be the backbone of pharmacy. How much quality pharmaceutical care can any pharmacist deliver without well-trained, educated and experienced technicians backing him/her up in the drug distribution process? I think that we, as pharmacists, have an obligation to the pharmacy technicians working with us to speak up for them in the area of financial compensation. When a potential student calls me or comes by to see me at Durham Tech, he/she obviously asks about the starting salary paid to graduates of our Pharmacy Technology diploma program. Most potential students (potential pharmacy technicians) cannot believe that the income level is so low. The other health technology programs available at our college offer higher average salaries and salary ranges. Those career options are as follows: Dental Laboratory Technology ($24,000), Phlebotomy ($15,000-20,000), Associate Degree Nursing ($28,000-65,000), Practical Nursing ($18,800-35,000), Surgical Technology ($25,000), Occupational Therapy Assistant ($30,000-40,000), Respiratory Care ($40,000), and Opticianary ($26,000). I cannot in good faith tell them this is a one-step career choice. So I encourage them to consider working as a pharmacy technician as a stepping stone to other healthcare professions or to pursuing additional educational opportunities. I very much desire to train and educate those potential students in pharmacy technology. There is something special about a person attracted to the healthcare delivery profession. The potential pharmacy technicians that I meet desire to help other people. It is such a waste for these potential students to be turned away from pharmacy because they know they cannot survive economically on the current wages offered to them.

Why is the annual salary for a pharmacy technician so low? I stress low. Could it be that in North Carolina we really have no standards as to what requirements there are for one to be employed as a pharmacy technician? My opinion is that this is the case. Even with the passage of Senate Bill 446, the only accomplishment we have made is that those individuals employed in a pharmacy as a technician are registered with the Board of Pharmacy. I am glad that we have come this far in our state. Technicians should be identified by our profession through the registration procedure.

Senate Bill 446 states that the pharmacy technician must complete a required training program. What are the requirements of the training program? How long does it take to complete the training program? What are the outcome competencies demonstrated at the completion of the training program? How does a pharmacist-manager have the time to provide a required training program while the "technician" is working? I understand that different practice sites require a different knowledge basis and training, but surely the profession of pharmacy in North Carolina should have a baseline standard of what education and training of a pharmacy technician should be. Now I read that a simple one-day review course for the certification exam will satisfy the requirement worded in the bill specifying the areas of pharmacy terminology, pharmacy calculations, dispensing systems and labeling requirements, pharmacy laws and regulations, recordkeeping and documentation, and proper handling and storage of medications.

As a profession that needs pharmacy technicians to assist pharmacists in preparing and dispensing medications, we should have standards in our professional practice guidelines that specifically address the requirements of the pharmacy technician in his/her training and education. As it is now, not all technician employers require certification of all technicians.

As pharmacy professionals, we have an obligation to ourselves and those we serve to insist that mandatory requirements of education, training and certification be criteria for hiring pharmacy technicians in any pharmacy setting. I suggest that we do this within our professional standards of practice. Pharmacists depend on pharmacy technicians in the drug distribution processes. We expect them to be dependable, honest and professional. The pharmacy environment needs well-trained and educated technicians more that ever. The more we expect of them, the more their wages should increase.

People who will hopefully pursue a career do so because of their desire to be part of a lifelong goal. People also expect a fair payment for their services from their employers. If not found to be satisfying personally with decent compensation, people will choose other pathways in life to satisfy themselves personally and financially. ❖

About the Author...

Joe Anne Griffith, RPh, is Instructar/Clinical Coordinator in the Pharmacy Technology program at Durham Tech. She can be reached via e-mail at griffithj@gwmail.dtcc.cc.nc.us

OPINION

Why Should APhA Become the American Pharmacists Association?

By Bruce Canaday
Director, Pharmacotherapy Department, Coastal AHEC
Wilmington, NC

After 150 years as the American Pharmaceutical Association, why should APhA change its name now? I think the answer is simple. When people don't know who you are and whom you represent, it's time to rethink what you call yourself.

Let me explain. To many of us, the question of who APhA represents is easily answered. APhA is the national professional society of pharmacists. But when we get outside the pharmacy family, the situation is quite different. Outside pharmacy, many people think APhA represents the pharmaceutical manufacturers. For example, an article in the *Washington Post* in March 1999 stated, "A spokesperson for the American Pharmaceutical Association, which represents non-prescription drug manufacturers, supports the changes to OTC drug labels." Say what???

On a daily basis, APhA receives numerous misdirected telephone calls that must be referred to the Pharmaceutical Research and Manufacturers of America (PHARMA) and other industry trade organizations. Further, our current name frequently creates barriers in communicating the Association's key messages. It conveys a focus on drug products rather than a focus on the health professionals and scientists who make up our Association's membership. If you have only a few minutes to talk with members of Congress and their staff members, it detracts from your messages and reduces your impact if you have to spend the first half of the conversation explaining who you are.

Back when APhA was founded, the common parlance of the time suggested that "pharmaceutical" was an appropriate term to describe APhA. But with the post-World War II explosion of the drug industry, the terms "pharmaceutical" and "pharmaceuticals" grew increasingly associated with medications and the drug industry itself.

So, at its Annual Meeting celebrating its 150th year of service, APhA announced that a new name would better reflect the organization's focus. That focus is on you and me. That focus is on pharmacists – the health care professionals whose contemporary mission is to help patients make medications work. The proposed name—American Pharmacists Association—would eliminate public misperception of APhA as being an association representing the pharmaceutical industry and highlight our real focus. This change gives us a name that quickly, accurately, unambiguously, and concisely conveys to the public who we are and who we represent.

The APhA Board of Trustees has authorized bringing the name change to the membership for discussion and a vote. The Board's recommendation is that "pharmacists" become the distinguishing feature – the focus - in APhA's name, as they have been in its history and will be in its future. In a mail ballot, members will be asked to approve the change to the American Pharmacists Association.

The Association was founded by pharmacists, has been led by pharmacists, and works tirelessly to enable pharmacists to serve the American public. If you are an APhA member, join me in telling the world who we are and the vital role pharmacists play in the health care system. Vote in favor of the name change. ❖

The North Carolina Association of Pharmacists welcomes your editorials and opinions. Articles may be published in *North Carolina Pharmacist* or posted on the NCAP web site at www.ncpharmacists.org. Please contact NCAP for more information and submission guidelines.

Bayer

Cardinal Health

NCAP Spring Meeting Highlights

NCAP's Spring Meeting brought nearly 400 pharmacy professionals together April 21-23 at the Sheraton Imperial Hotel & Convention Center in Research Triangle Park, NC.

The meeting began with Sunday evening concurrent symposia covering the Rational Use of Antibiotics for Respiratory Tract Infections and an Update on Asthma. The evening ended with a Dessert Reception. Monday's sessions included several topics on Bioterrorism and the Pharmacy Profession. Other topics covered many areas including the NC Medicaid Program, Sepsis Management, and Reimbursement and the Clinical Pharmacist Practitioner.

A special thanks goes to our meeting sponsors who provided generous support for our continuing education programs. Platinum Sponsors included Bayer, Cardinal Health, Pfizer and Wyeth Pharmaceuticals. Gold Sponsors included Eli Lilly & Co. and Scios Inc. The Silver Sponsors were AmerisourceBergen, IDEC Pharmaceuticals Corp., Odyssey Pharmaceuticals Inc., and Purdue Pharma L.P.

Pfizer

Wyeth Pharmaceuticals

Campbell University Grads Accept Residencies

The following is a list of Campbell University graduates who have accepted residencies this year:

Rina Ackerman, PharmD, Pharmacy Practice Resident, Southeastern Regional Medical Center, Lumberton

Anjali Arora, PharmD, Drug Information Resident, Campbell University Pharmacy School

Jack Dean, PharmD, Pharmacy Practice Resident, Veterans Affairs Hospital, Huntington, WV

Wendy Dean, PharmD, Pharmacy Practice Resident, Veterans Affairs Hospital, Huntington, WV

Lisa Easterling, PharmD, Family Practice Resident, Moses Cone Medical Center, Greensboro

Mary Beth Grizzard, PharmD, Pharmacy Practice Resident, Pitt County Memorial Hospital, Greenville

Luke Heuts, PharmD, Pharmacy Practice Resident, Duke University Medical Center, Durham

Jennifer Hopson, PharmD, Community Pharmacy Resident, Ward Drug and Campbell University School of Pharmacy

Brooke King, PharmD, Primary Care Resident, Cary Health Associates and Campbell University School of Pharmacy

Jennifer Peterson, PharmD, Pharmacy Practice Resident, Veterans Affairs Medical Center, Durham

Jennifer Dixon Smith, PharmD, Primary Care Resident, Wilson Community Health Center and Campbell Unversity

Harold Sano, PharmD, Oncology Resident, Walter Reed Army Medical Center

Julie Tolle, PharmD, Primary Care Resident, UNC Hospitals, Chapel Hill

Leslie Wagstaff, PharmD, Drug Information Resident, Glaxo Smith Kline, RTP

Melissa Ware, PharmD, Visiting Scientist, Eli Lilly and Company, Rockville, MD

These individuals graduated in May 2002 with their PharmD. We wish them well in their new positions.

UNC-Chapel Hill School of Pharmacy News Update

• Jena Ivey, a UNC Yingling Scholar, received a Schweitzer Fellowship for her project addressing health literacy and medication use among the elderly in Orange County, NC. Her preceptor for this project is Mary Roth, Clinical Assistant Professor.

• The School held its annual Chocolate Day celebration on April 5, 2002. This spring celebration, sponsored by Eckerd Drugs consists of build-your-own ice cream sundaes on the front lawn of Beard Hall. The entire health sciences campus turned out for this event... and we enjoyed ice cream and hot fudge down to last marachino cherry!

• The School held its annual Family Day program on April 13, 2002. Dean William H. Campbell was the keynote speaker. Family and friends enjoyed participating in mock lectures/labs and learned more about the student organizations at UNC. Everyone enjoyed a feast on the Beard Hall lawn that day.

• The School held its annual awards and scholarship celebration on April 27 in the Morehead Ballroom.

• Thirty-eight of 113 graduates (Class of 2002) were selected for post-graduate training programs (i.e., residencies, fellowships, graduate/professional schools). This is an increase of 4% over 2001,with much of the gain occurring in the area of community pharmacy residencies.

Kim Ellis, rising PY3, scoops ice cream for fellow students at UNC's Annual Chocolate Day.

• Commencement activities were held on May 19 at the Carmichael Auditorium. Richard P. Penna, PharmD, Executive Vice President of the American Association of Colleges of Pharmacy was the keynote speaker.

• Tina Brock, Clinical Associate Professor, and Scott Smith, Assistant Professor, were selected for the National Library of Medicine Medical Informatics Fellowship in Woods Hole, MA. In addition, both were awarded grants from the Provost's Office to develop an interdisciplinary distance-based health care informatics course. A portion of this course, to be offered in spring 2003, will also be offered as a certificate program for practicing pharmacists in partnership with the School of Public Health.

Small Doses

NCAP Web Site Receives Recognition

NCAP's web site was noted as one of the leading association web sites in the Southeast in the May issue of *The Southeastern Association Executive Magazine*. The article addressed the use of public relations tools for associations and included an interview with NCAP staff and large color graphics of the site. If you haven't visited www.ncpharmacists.org lately, what are you waiting for?

NCAP Sponsors APhA Student Breakfast

NCAP was recognized in the May/June 2002 issue of the American Pharmaceutical Association's magazine *Pharmacy Student* for its sponsorship of the APhA Political Leadership Breakfast held at the APhA Annual Meeting in Philadelphia. Through generous contributions from many sponsors, over 120 pharmacy students were able to attend the Association's leading political event. The Political Leadership Breakfast tries to impress upon pharmacy students the importance of political activism and encourage students to "return the favor" and give back to the profession in the years following graduation from pharmacy school.

Jones Named AHEC Faculty of the Year

Martha Jones, Director of Pharmacotherapy at Area L AHEC, Scotland Neck, and Clinical Assistant Professor of Pharmacy at UNC-Chapel Hill School of Pharmacy, has been named AHEC Faculty Preceptor of the Year. Each year UNC pharmacy students nominate an AHEC faculty preceptor for this award. Students base their nominations on many things, including leadership, quality patient care, progressive pharmacy practices, contributions to the advancement of health care, and excellence in teaching. Martha precepts approximately 12 students each year.

Skakle Publishes Memoir

Auxiliary member Sybil Austin Skakle of Chapel Hill has published a new memoir, *"Confessions of an Outer Banks Filly."* Her family goes back to the 18th century on the Outer Banks where she grew up in Hatteras. She is a graduate of the UNC-Chapel Hill School of Pharmacy and worked as a pharmacist for 23 years. Some of the essays in her memoir have been published separately and the positive responses she received encouraged her to write the book. The book is available at Barnes & Noble and Borders Books.

NCAP Member Named "Tarheel of the Week"

NCAP member Gina Upchurch was recently named "Tarheel of the Week" by the *Raleigh News & Observer*. Gina is the Executive Director of Senior PHARM*Assist* in Durham, a community-based, non-profit program that helps seniors with limited income obtain medication, improve health literacy, and connect with community resources including meals and transportation. Gina earned her Bachelor's degree in Pharmacy from UNC-Chapel Hill in 1986. A long list of her many accomplishments includes receiving a Robert Woods Johnson Foundation Community Health Leadership grant in 2001, being named North Carolina's 2001 National Pharmacist of the year by *Drug Topics* magazine, receiving the George L. Maddox Award for innovative programming for older adults, as well as receiving numerous awards for services to senior citizens.

Kerr Drug Receives National Attention

Kerr Drug Store in Chapel Hill was featured in the June 16th edition of *The New York Times*. The article focused on Kerr's efforts to expand the definition of "pharmacy" by providing a wide range of health management services including bone-density testing, diabetes and cholesterol monitoring, stop-smoking clinics and courses on women's health issues. These Enhanced Pharmaceutical Care Centers have specially trained staff, private counseling rooms and meeting space for groups.

Diabetes Golf Classic

The 2nd Annual Charles Ray III Diabetes Golf Classic will be held October 7, 2002 at MacGregor Downs Country Club in Cary, NC. Founded in 1998, the Charles Ray III Diabetes Association was created to provide education, inspiration and diabetic testing supplies to those unable to afford supplies and do not have adequate health insurance. The Association has already helped hundreds of diabetics in North Carolina and around the world. To register for the golf tournament call 919-303-6949 or visit www.charlesray.g12.com.

CONTINUING EDUCATION

In order to better serve our members, NCAP will mail a special CE Supplement only to members who request it. CE is no longer published in North Carolina Pharmacist, leaving more room for news of interest to all readers. As always, Continuing Education is available only to members. Members who would like to be added to the mailing list for CE should contact Teressa Reavis at teressa@ncpharmacists.org or call 919.967.2237 ext. 27.

Sponsored by

PHARMACIA

Calendar

Sept. 7-8: ***Pharmacy Practice Seminar***, Wilmington Hilton Riverside, Wilmington, NC. Programs for pharmacists in community ambulatory care and long-term care practice. Sponsored by the UNC-CH School of Pharmacy, Coastal AHEC, PharmCon, Inc. and NCAP. Call 919-966-1128 or visit the Meeting & Events section of the NCAP web site for a registration form/brochure.

Oct. 9-11: ***NCAP Annual Convention***, Sheraton Four Seasons, Greensboro, NC. For more information call 919.967.2237 ext. 22 or visit the NCAP web site at www.ncpharmacists.org

North Carolina Pharmacist

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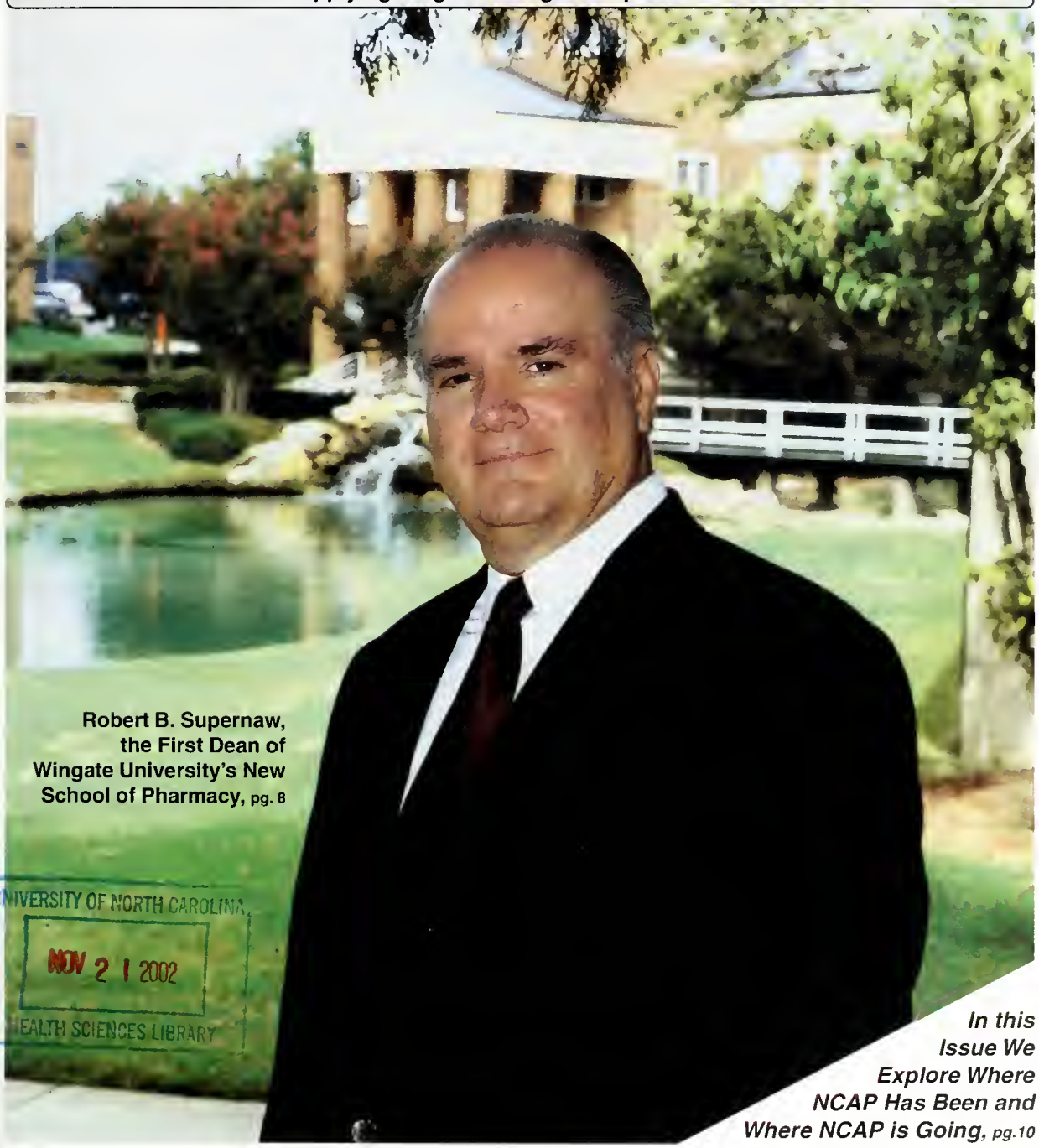

Robert B. Supernaw, the First Dean of Wingate University's New School of Pharmacy, pg. 8

In this Issue We Explore Where NCAP Has Been and Where NCAP is Going, pg.10

MUTUAL DRUG

Established by Pharmacists in 1952, Mutual Drug has been serving the needs of independent pharmacies for 50 years.

We are able to focus all of our attention on providing the best programs and services for THE INDEPENDENT.
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"REACH ONE FOR NCAP"

NCAP Membership Campaign

NCAP is seeking the help of its members to increase membership in the Association. Please encourage a friend or a co-worker who is not a member to join. Sponsorship will earn you an entry in a drawing for a free one-year NCAP membership (Drawing to be held at the 2003 Convention). Your primary reward will be the satisfaction you receive from seeing your Association grow.

HELP OUT - "REACH ONE FOR NCAP"

North Carolina Association of Pharmacists - 2003 Membership Application

Full Name _____ Degree _____ DOB _____

Title _____ Business Name _____

Work Address _____

_____

Work Phone (_____) _____ Work Fax (_____) _____

College: _____ Class Year: _____ NC Pharmacist License# _____

Home Address _____

_____

Home Phone (_____) _____ Home Fax (_____) _____

Preferred E-mail _____ Sponsor's name _____

Preferred (Mailing Address): _____ Home _____ Work

Membership Categories: (Circle One)

Active Pharmacist: $175.00 **Associate** (non-pharmacist): $175.00 **Joint** (both husband & wife): $270.00 **Retired Pharmacist**: $95.00
Resident/Fellow: $95.00 **Out of State**: $95.00 **New Graduate** (2002): $95.00 **Pharmacy Technician**: $35.00 **Student:** $10.00

All membership dues include membership in a Practice Forum: (Circle One)

Acute Care (Hospital) Ambulatory Care (Community) Chronic Care (Long-Term) Technician

NCAP President's Club: I wish to support NCAP by making a tax-deductible contribution to the NCPhA Endowment Fund.
(Platinum Member-$1,000.00+ Gold Member-$100.00+ Silver Member-up to $99.00)

Payment Information: (check one): Check Enclosed _____ MC _____ Visa _____

Card Number: _____ Expiration Date: _____

Signature: _____ Date: _____

If you're using a credit card, please fax this form to (919) 968-9430. If you have any questions please call: (919) 967-2237 or (800) 852-7343. Otherwise, please mail the form and your check to: NCAP, 109 Church Street, Chapel Hill, NC 27516

Membership Dues: $_____
Contribution to President's Club: $_____
Total Enclosed: $_____

If you would like to join the Local Association in your area, you can find a complete list and their contacts on the NCAP web site under the Governance tab at www.ncpharmacists.org

12% of your membership dues are non-deductible for Federal income tax purposes due to lobbying activities conducted by the Association on behalf of its members.

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North Carolina Pharmacist

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Inside

Fred Eckel
Executive Director

Providing a Strong Foundation for a Bright Future

I believe that NCAP is surviving and hopefully moving towards thriving. But we all have our work cut out for us if we are to thrive. Social philosopher Robert Putnam's recent book, *Bowling Alone*, describes the decade's long pattern of disengagement from public life in our country. NCAP has experienced this in our lack of membership; difficulty in finding multiple candidates to run for office and the amount of professional apathy among many pharmacists. There is hope. Most scholars suggest that current college students, the next generation to come into the work place, are different. They care and want to get involved and make a difference, suggesting a bright future if we provide them with a strong foundation. That is what NCAP is trying to do.

"Reach One for NCAP" Campaign

Our staff and Membership & Marketing Council are asking each of us to help promote new members in our "Reach One for NCAP" campaign. We generated 253 new members this year so that our total membership now stands at 2090. We are ahead of last year, and if this trend continues, we will be in a position to hire an Executive Director after 2003. Thank you for your help.

Building Sale

After the Second World War a group of dedicated pharmacists raised money to build the Institute of Pharmacy in Chapel Hill. The building was dedicated in 1950 and continues to be the home of NC Pharmacy. Occasionally there is talk about another location, such as Raleigh, being a better site, but NCAP is not in a position to move now. The Board plans to decide on November 21 whether to accept the offer to buy our building and let NCAP rent space from the Pharmacy Foundation of NC, an organization started by NCPhA to support the UNC School of Pharmacy. If our members and friends agree to contribute sufficient funds to an Endowed Building Fund, we will not need to sell.

Organizational Structure

Any new organization has growing pains, and NCAP is no exception. Now that we have almost three years of experience we need to assess our Bylaws and perhaps make some changes. These questions will need to be addressed:

1. What should be the appropriate relationship between NCAP and local associations?
2. Is the House of Delegates the best way to make policy in the 21st Century, and if so, how should delegates be named?
3. What is the best way to offer educational programming for the special interests of pharmacists and meet our Practice Forum needs?
4. Do we have the right Practice Forums, and do we have the right structure for them?

NCAP's Mission

To prepare for our future we need to find a way to obtain payment for cognitive services separate from drug product dispensing reimbursements. Not every pharmacist agrees that pharmacy in general should be putting energy into cognitive services reimbursement because it won't happen, and even if it does, it will not help community pharmacy practice. Some are concerned that efforts to promote cognitive services reimbursement will hurt the effort to preserve the dispensing fee. Others believe this is our only future and all our energies should be put into this effort. NCAP's mission must address both sides of this pendulum.

NCAP needs to focus energies on both protecting the dispensing fee and promoting cognitive services reimbursement. Maintaining this balance will be critical to pharmacy and NCAP's success. A strong organization will balance these efforts. Our members need to ensure that we maintain this balance of maintaining the present while we prepare for the future.

The 15 months I have served pharmacy and NCAP as Executive Director have gone by quickly. I have had fun, worked with some great people, served some innovative pharmacists and feel appreciated. Together we can make a difference in our profession and benefit the citizens of North Carolina. Pharmacy needs a strong organization looking out for the professional interests of pharmacists. With your help NCAP can be that organization. Renew your membership and help us recruit new members. Volunteer to serve on councils and committees. Consider running for an elected office. NCAP appreciates the support we have received. The staff join me in pledging our committment to earn your continued support. We want to make you proud of your professional pharmacy organization. ❖

North Carolina Association of Pharmacists
109 Church Street
Chapel Hill, NC 27516
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Ross Brickley
Presider

Dear Members,

Pharmacists have never faced a more challenging time. The health care needs of the people in North Carolina are growing as our "baby boomer" population begins to enter their retirement years. While the demand for health care is increasing, so are the underlying costs. Pharmacists are being asked to deliver an increasingly higher level of care. We are challenged to meet the increasing demand for high level clinical skills when there's barely enough time to do all of the other things we need to do every day. The politics of health care and a volatile marketplace can affect our ability to expand our practices to meet the needs of the patients in our communities. The Medicare out-patient drug benefit may place additional constraints on our ability to maintain a positive bottom line in our businesses.

When we think about obstacles, they become all we think about. When we say, "No, I can't do that," the same thing happens. We start believing ourselves and it doesn't happen. Pharmacists in North Carolina, faced with many reimbursement and staffing challenges, could easily become discouraged. But the creative members of our profession will grasp the moment, see the opportunities, and run with the ball. I can visualize those pharmacists now, in training. They're the ones taking nontraditional PharmD courses, sitting for certification exams, and otherwise continually educating themselves. Those are the pharmacists who are filling themselves with knowledge, imagining success, and imagining the future of pharmacy.

I see a bright future for pharmacy and pharmacists. A future that will reward those pharmacists who are not afraid to take the challenge and be creative in expanding their practices. Opportunities will appear in areas that haven't been imagined. NCAP is working diligently to assist and guide our members with the workplace challenges we are facing. Some of NCAP's member benefits are more visible than others. Pharmacists' quest for an expanded role in health care can be viewed as an intricate, challenging puzzle. NCAP is working on key pieces of the puzzle. But it's up to us, as individual pharmacists, to fashion the pieces into a cohesive whole. The window of opportunity is slowly opening for the pharmacy profession. Before it closes on us, let's put all the pieces of the puzzle together and pull ourselves to the other side and experience an expanded role in the health care continuum.

Sincerely,
Ross Brickley, RPh, MBA, CGP

...applying drug knowledge to improve health

Supernaw Named Dean of Wingate's Pharmacy School

Following an extensive nationwide search, Robert B. Supernaw has been named the first-ever dean of the School of Pharmacy at Wingate University.

Supernaw took his position at the helm of the newly-formed school on October 1, 2002. Classes are slated to begin in the fall of 2003. His first year will be spent building the infrastructure of North Carolina's third school of pharmacy, primarily recruiting faculty and students.

"The prospects of becoming the principal player in the development of a new school of pharmacy is an opportunity afforded to very few," said Supernaw. "I sincerely feel that with our prospective health care partners in the Greater Charlotte Area, we can contribute significantly to the quality of health care in the region."

The board of trustees at Wingate University endorsed plans for a School of Pharmacy after receiving a favorable feasibility study from the 12-member university pharmacy school task force, which has worked for more than 18 months. Dr. Jack Cole, dean emeritus of the University of Arizona, College of Pharmacy and consultant to the task force feels that Wingate University would possess a niche in pharmacy schools.

The task force found a significant demand for another school of pharmacy in the state. Only two schools of pharmacy exist in North Carolina, UNC-Chapel Hill and Campbell University. South Carolina also has only two schools of pharmacy.

"Starting a pharmacy school aligns with the principles of knowledge, service to humanity, and leadership as outlined in our mission statement," said Jerry E. McGee, president of Wingate University.

"North Carolina is fortunate to have two very fine schools of pharmacy but Campbell University and UNC-Chapel Hill simply cannot graduate enough pharmacists to meet the needs of our citizens," said McGee. "We look forward to working alongside them to assure that the needs of our region are met."

The school will offer a 2/4 pharmacy program, meaning students will enroll in two years of pre-professional courses followed by four years of professional courses. Class size is targeted at 60 students, which will add approximately 240 students to university enrollment.

Supernaw is a Doctor of Pharmacy and holds degrees from Long Beach City College, California State University at Long Beach, University of the Pacific, San Joaquin Delta College and the Institute of Biofeedback in San Francisco. He and his wife Diane, have two children, Aaron (29) and Tara (26).

Supernaw comes to Wingate University from Texas Tech University in Amarillo, where he has been associate dean and a professor since 1998. He was previously a pharmacy professor at University of the Pacific in Stockton, CA, where he also served twice as interim dean from 1983-1984 and 1995-1997.

His lengthy resume includes numerous professional affiliations, nearly 75 professional papers that have been published and research stints with major pharmaceutical companies; most notably for Bayer and Proctor-Syntex, for whom he helped launch Aleve pain reliever. He has also served as the Editor in Chief for the *American Journal of Pain Management* since 1991, is a registered pharmacist in California and Nevada and is board certified by the American Academy of Pain Management and the American Board of Forensic Examiners. ❖

NCAP Nears Three Year Mark

Where Have We Been, Where Are We Going Now?

Almost three years ago the North Carolina Association of Pharmacists was formed. A merger between the North Carolina Pharmaceutical Association, the North Carolina Chapter of the American Society of Consultant Pharmacists, the North Carolina Retail Pharmacy Association, and the North Carolina Society of Health-System Pharmacists brought NCAP to life. We contacted members of the 1999 Driving Committee who guided the merger to ask what kind of progress they believe NCAP has made in its first three years. We also wanted to know, in the Driving Committee's opinion, what direction NCAP should be taking. Six of the eleven members responded as follows.

Kevin L. Almond
Associate Dean
UNC-CH School of Pharmacy

After nearly three years in existence, what kind of progress has NCAP made?

I think the biggest change is the mix of topics in CE programs. Programs have been created that should appeal to most every practitioner. It's still a work in progress, however, and practitioners have a chance to mold those programs through their evaluations. Though there are still groups outside of NCAP positioning themselves to speak for pharmacy, there seems to be more acknowledgment by media and legislature that we are the place to go for answers to many health care questions. That's real progress.

In retrospect, was merging four state pharmacy associations the right thing to do and would you have done anything different?

Merging was and is the right thing to do. We may have tried to do it too quickly and tried to force different pharmacy groups to change how they do business. The result is, our growth is probably where it would be had we gone about it more slowly. Getting buy-in and enacting large-scale change is difficult and is not done overnight. There is still room for growth and Executive Director Fred Eckel is committed to steady growth. I can think of no other person in the state who would dedicate their time to this project and try to get opinions from every facet of our profession. Other states have been successful in consolidating their associations, and I think we are still moving in the right direction.

From this point, what do we need to do in order to get where we need to be?

There are, and will always be, adversaries to one organization. What professional dissension exists may be due to a perception of loss of power or autonomy. We can all look back to "the good ol' days" for comfort, but those days are gone for retail, health systems, industry, etc. We need to create the good ol' days for future pharmacists and that requires change. I think NCAP, along with the schools of pharmacy and the Board, should be leading the charge and not just keeping up. We need to get a critical mass of our practitioners dedicated to being ahead of our politicians and insurers. Scurrying around to keep up with their myopic view of health care is detrimental to pharmacy and to our patients. We have to identify and put forth colleagues who will encapsulate an NCAP vision and lead pharmacy through this decade. To do that, it will take more than 2,000 of our 8,000 North Carolina registered pharmacists. Membership is critical and those members will have to become involved instead of sitting in the stands watching the game.

Vance Collins
Clinical Coordinator
Halifax Regional Medical Center

After nearly three years in existence, what kind of progress has NCAP made?

In my opinion, NCAP currently exists in surviving mode as compared to thriving mode; however, progress in some important areas has been made that I believe will lead us to be successful in the future. Pharmacy is as diverse a profession as it has ever been and it will continue to be extremely hard to meet the individual needs of all members. The most important fact I believe we have learned is that it is imperative to work together, to speak with one voice, in order to get anything meaningful accomplished. Internally, we are beginning to understand the importance of issues faced by different practice settings and have greatly improved our communication with each other.

In retrospect, was merging four state pharmacy associations the right thing to do and would you have done anything different?

It has sometimes been a difficult road with many obstacles, but merging was still the right thing to do. We assumed that most North Carolina pharmacists are as passionate about their profession as the driving committee members. Looking back, apparently we were wrong, considering the number of pharmacists in the state compared to those who joined NCAP. Apparently a significant portion of North Carolina pharmacists have become "blue collar" workers. Financial stability was based mainly on membership so obviously, our financial picture has not allowed NCAP to do some of the things we had planned that would benefit our members. We also thought that local associations across the state would meet the need for grassroot communications and serve as a local connect for NCAP. This may have worked for some local associations with strong leadership but it failed overall. We also assumed that the four previous organizations would fully merge (100%) into one organization. Some organizations or parts of the organizations kept their previous structure until well after the merger occurred, possibly to 'wait it out" and see if NCAP could survive. This appeared to keep NCAP divided. With the exception of Acute Care and possibly Chronic Care, the practice forums were not well structured for some time after the merger. This led to the needs of some members being overlooked or not addressed.

From this point, what do we need to do in order to get where we need to be?

Membership/financial stability remains a key component of survival in order to be where we would like to be. Hopefully, North Carolina pharmacists will begin to notice what NCAP is trying to accomplish for them and realize the value of their membership. It is imperative for the Practice Forums to be active and address the concerns of their membership since the forums have become the

...continued page 10

grassroots contact for the Association. The leadership of the Practice Forums should be held accountable by the Board of Directors. Educational programming should be divided into concurrent sessions planned by each Practice Forum to meet the specific needs of the Practice Forum members. We need to involve members who want to participate and let those in leadership positions who are not participating gracefully bow-out. We all need to be able to accept the changes occurring in our profession and adapt to these new opportunities.

Dan Garrett
Senior Director
Medication Adherence Programs
American Pharmaceutical Association Foundation

After nearly three years in existence, what kind of progress has NCAP made?

NCAP has made significant progress in its first two years with the passage of the Clinical Pharmacist Practitioner and Pharmacy Technician Acts. More importantly, NCAP was successful in working with the Medical and Pharmacy Boards to get the regulations for CPP's in place and there are now practicing CPP's helping patients. The Pharmacy Technician bill process is a great example of how NCAP brought together diverse interests in pharmacy to develop a bill that met the needs of all pharmacy practices, advanced the status of pharmacy technicians, and positioned the ability of pharmacy technicians to free up pharmacists' time for patient care.

NCAP has also served in a supportive role in the continued struggle for fair reimbursement for dispensing prescriptions with the North Carolina Medicaid program. Compared to other states, the pharmacists in North Carolina still have one of the better Medicaid reimbursement rates.

Another strength that the unification has had is in the increased coordination of educational programs and conferences for pharmacists. Offering CE that meets diverse practice needs is always a moving target and NCAP has helped bring together pharmacists from different practice environments at increasingly larger meetings with multiple offerings.

In retrospect, was merging four state pharmacy associations the right thing to do and would you have done anything different?

Merging the organizations was definitely the right thing to do and this is exemplified by the increasing number of other state associations that are merging.

From this point, what do we need to do in order to get where we need to be?

Keep putting the message out about the good things that NCAP is doing for pharmacists and pharmacy technicians and encourage membership growth, especially for new pharmacists and students.

William Harris
Clinical Pharmacist, Medication Safety
Duke Medical Center Hospital Pharmacy

After nearly three years in existence, what kind of progress has NCAP made?

Progress has been made in:

- Members understanding the factors that affect the pharmacy profession as a whole, rather than just our own unique pharmacy world.
- Looking outside our practice "silos" to learn more about how others practice pharmacy and what is important to these pharmacists and their patients.
- Avoiding conflicts within the pharmacy profession by discussing the issues in NCAP committees, councils, practice forums, board and executive committee meetings.
- Reducing or eliminating competition and conflicting messages and goals in the legislative realm where the lack of clear, focused goals are certain defeat.
- Increased methods of communication to pharmacists and technicians who have an interest in (1) improving the profession, (2) pursuing new areas for pharmacists to work and (3) directing pharmacy practice changes rather than letting outside forces control our future.
- Identifying and communicating the value of pharmacy technicians to the profession.
- Networking with pharmacists and technicians whom we did not even know three or four years ago.
- Building a pharmacy family in North Carolina with a sense of community and respect for everyone who practices pharmacy.

In retrospect, was merging four state pharmacy associations the right thing to do and would you have done anything different?

I believe it was the right thing to do for the pharmacy profession in North Carolina. Each of the founding organizations was experiencing similar problems and all were competing in the same pool for members, funding and support.

At the time, the leaders of the four organizations believed that the merger process was open, organized and completed in a reasonable time frame. Perhaps we could have worked even harder to receive more local association involvement, discussion and feedback.

From this point, what do we need to do in order to get where we need to be?

• NCAP needs more members. Our membership growth has been too slow to achieve the goals envisioned by the Driving Committee and leaders of the NCAP Practice Forums. Everyone needs to become an active NCAP recruiter.
• We need more representation and active participation from students, new graduates and pharmacists in the early stages of their professional careers. NCAP must become more visible in the pharmacy schools and get the message to all students that NCAP participation is important and necessary to pharmacy practice.
• NCAP needs more people to seek leadership roles.
• We must make NCAP more visible and involved in all aspects of heath care in North Carolina and educate all patients and providers about the value that pharmacists provide in patient care.

Davie Waggett
Owner, Seashore Discount Drug
Wilmington, NC

After nearly three years in existence, what kind of progress has NCAP made?

With two years gone by, I feel that some significant progress had been made. One of my disappointments has been that not all major players came into the fold. The one player that has not come into the fold has not come because they are worried about the quality of continuing education that they might receive. I say "come on in and help us fix it; be a part of the solution." That group certainly will have no clout when it comes to legislative issues, because of relatively small membership. When it comes to legislative issues, the "one organization, one voice" attribute is of paramount importance. We are still suffering with that situation because even though we are mostly united, the membership numbers are relatively unchanged, and therefore, our clout is weakened.

We have made some progress in legislative matters, but these were matters that were not of primary importance to present day pharmacy. One such bill was passed to insure that all third-party insurance information on prescription cards was standardized and available on a magnetic strip on the back of the card. The bill passed, but two years later it is not in force. The Clinical Pharmacist Practitioner bill was passed, however, it affects only a few pharmacists at the present time. It is an important bill, but without teeth until we get insurance companies to recognize pharmacists as "providers."

The primary legislative issue in pharmacy, in my opinion, is third-party insurance reimbursement. Although, on the surface, it appears to affect only the retail pharmacists (independent and chain), I feel that it affects all of pharmacy because if not remedied, all pharmacists will feel the affect. With insurance reimbursement for prescriptions at an all time low, retail pharmacies are not able to cover the costs to do business and therefore, if left without a remedy, many will fail and go out of business. If many retail pharmacies close up, the shortage of pharmacists will reverse into a large surplus across the nation. A large surplus of pharmacists will lower compensation to pharmacists in all fields, flood the fields, and negatively affect healthcare. I feel that NCAP should have "come out swingin'" when they were reorganized, and made this a primary focus.

In retrospect, was merging four state pharmacy associations the right thing to do and would you have done anything different?

Yes, uniting the four associations is the right thing to do. We all have some common grounds to play on, as well as some diversification. We should unite on the common grounds and help each other, when we can, on non-related issues. We have forums from each practice formed to address the diversification.

From this point, what do we need to do in order to get where we need to be?

We need to move forward with increasing the membership, not for numbers sake, but because there is strength in numbers. We need the membership strength in order to secure the future of pharmacy and pharmacy care in North Carolina. NCAP needs to be able to reach all pharmacists in North Carolina, to keep them informed, and keep them up to date on educational, health, and legislative matters.

Tim White
Hayes-Barton Pharmacy
Raleigh, NC

After nearly three years in existence, what kind of progress has NCAP made?

I'm not real sure. Some good things have come out of NCAP such as the CPP legislation and the Web site, yet after my stint on the Board I have to admit that I do not see much in the community in regards to NCAP other than the weekly E-News that is helpful. Yet, I know more is going on than I am exposed to and wonder what can be done better.

In retrospect, was merging four state pharmacy associations the right thing to do and would you have done anything different?

It was the right thing to try. I'm not sure if we accomplished much, yet we tried. The process is an evolution and hopefully will continue. I do believe the different aspects of pharmacy have a better appreciation for each other, yet there remain challenges to get us on the same page for legislative issues. I was glad to see the chains work with the independent pharmacy lobbyists in this past session on a number of issues.

From this point, what do we need to do in order to get where we need to be?

Keep plugging. Provide CE that crosses over pharmacy divisions. Move our headquarters to Raleigh. When funds are in order, hire an executive director that is an effective lobbyist. ❖

UNC-CH External Doctor of Pharmacy Program Anticipates Admitting Final Class in Fall 2003

The External Doctor of Pharmacy Program was designed to meet the needs of practicing pharmacists, and to continue operating as long as sufficient interest remained to sustain the Program. Our original estimate was for a 10-year period of operation. In reviewing our recent application and enrollment trends, it appears this estimate is correct. Therefore, we anticipate admitting our final class in Fall 2003. Applications will be available in January 2003. The application period will be from February 1 through May 1 for the Fall 2003 Semester. To request a brochure or application, please contact Cathy Hardee: phone: 800/257-3561 or 919/962-5000; fax: 919/843-9255; e-mail: cathy_hardee@unc.edu. Additional information about the External PharmD Program is available at: www.pharmacy.unc.edu/pharmacy/programs/externalPD/index.html.

Pamela Joyner, EdD, MS, Associate Dean for Professional Education,
UNC-CH School of Pharmacy, Beard Hall – CB #7360,
Chapel Hill, NC 27599-7360

NCAP's 2002 A

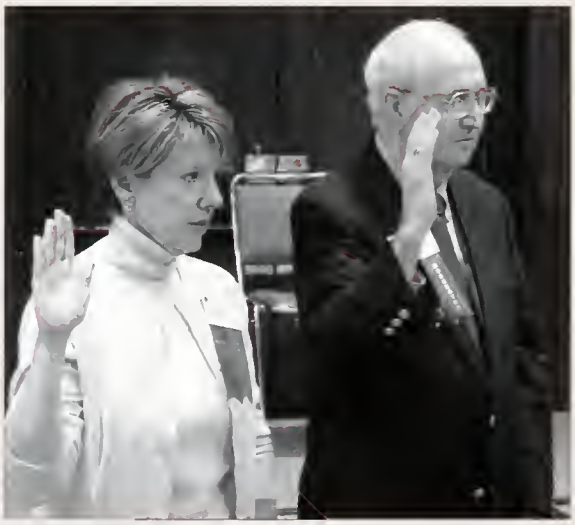
Over 600 pharmacy professionals attended the North Carolina Association of Pharmacists 2002 Annual Convention in Greensboro on October 9-11 at the Sheraton Greensboro Hotel/Koury Convention Center. An NCAP awards ceremony was held Thursday evening to honor those who have contributed in various ways to the pharmacy profession. The program was followed by a reception featuring a jazz quartet. The annual meeting was co-sponsored by the UNC-CH School of Pharmacy, Campbell Universtiy School of Pharmacy and Greensboro AHEC.

Fred Eckel (r) presented Pharmacists Mutual Companies Distinguished Young Pharmacist Award to Beth DeWitt Greck (l).

Laura Brewer (r) presented the Ambulatory Care Pharmacist of the Year Award to Betsy Bryant (l).

Betty Dennis (l) was named Acute Care Pharmacist of the Year. Ashley Holstrom (r) of Pfizer, Inc. presented the award.

For his outstanding service to NCAP, Bill Harris (l) received the Presidential Award from President Ross Brickley (r).



Anna Garrett (l) and Jack Watts (r) were sworn in during the Installation of Officers ceremony. Anna will serve as Chair of the 2003 Acute Care Practice Forum and Jack will serve as President of NCAP during 2003.

Margaret Randall places roses in a vase to honor members who have died in the past year during the Rite of Roses ceremony.

Barry Bunting (l) received the Don Blanton Award from Olin Welsh (r) for contributing to the advancement of pharmacy in North Carolina.

Gigi Davidson (l) received the Campbell University Preceptor of the Year Award from Larry Swanson (r). Not pictured is Angela Pegram who received the UNC Preceptor of the Year Award.

For her outstanding record of community service Gina Upchurch (l) was presented the Wyeth Bowl of Hygeia Award by Thomas Suter (r) of Wyeth Pharmaceuticals.

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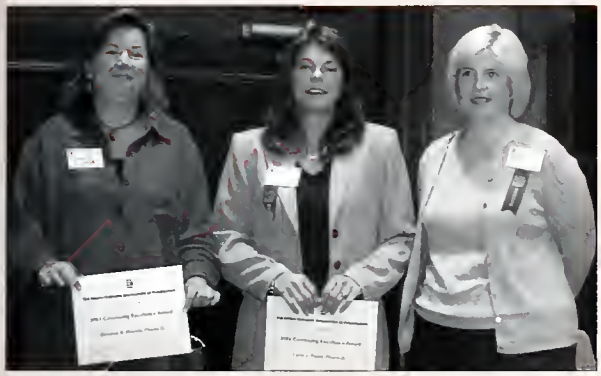

Acute Care Practice Forum Chair Jane Younts (r) presented Continuing Excellence Awards to Deanna Moretz (l) and Lorie Poole (center). Not pictured: Christine Atkins, James Beardsley, LeAnne Kennedy, and Elizabeth Oldham.

The NCAP Auxilliary presented scholarships to pharmacy students during a special luncheon. (l to r) Scholarship recipient Marjorie Adams of UNC-CH School of Pharmacy, NCAP Auxilliary President Margaret Randall, scholarship recipients Meghan Peters and Shannon Holland of UNC. Not pictured: Jessica Seller, Russell Frazer, Irene Rwakazina and Nannette Murray of UNC, and Kaye Dunham of Campbell University School of Pharmacy.

The Fifty Plus Club honors members who celebrate fifty years as licensed pharmacists. Those attending the convention included (l to r) Keith Norman Fulbright, Bill Randall, Harold Day, Alec Clelland, and George Cocolas.

The Elan Biopharmaceuticals Innovative Pharmacy Practice Award was presented to Donald Holloway (l) by Stephen Caiola (r).

NCAP President Ross Brickley (l) received the NCAP President's Award from Bill Harris (r).

Joe Johnson (l) received the NCAP Presidential Award for outstanding service to NCAP from Ross Brickley (r).

The National Community Pharmacists Association Pharmacy Leadership Award was presented to Jack Watts (l) by Whit Moose, Sr. (r).

Larry Long (l) received the Chronic Care Pharmacist of the Year Award from Ross Brickley (r).

Merck & Co. representative Ken Tuell (r) presented the Merck Pharmacy Leadership Award for outstanding leadership to Ross Brickley (l).

Bristol-Myers Squibb representative Lamar Pritchard (r) presented the Bristol-Myers Squibb Pharmacy Leadership Award to Ross Brickley (l).

Mckesson representative Curt Sell (r) presented the McKesson Leadership Award to NCAP President-Elect Jack Watts (l).

Incorporating PDA Technology into Pharmacy Practice

In recent years, there has been a shift in the pharmacist's practice. As pharmacotherapy decision-makers, we are responsible for the details that go with deciding which dosage and which dosage interval will be best for the patient. We also have to know which drug is on the formulary and its relative cost. There are many details to know when making pharmacotherapy decisions.

Pharmacists at Moses Cone Hospital decided to investigate PDA (Personal Digital Assistant) technology to help us manage the data. A team was formed and a plan made.

What Plan was developed for Clinical Practice?

Goal 1: Utilize various databases to pull together patient-specific information with the hopes of creating a paperless monitoring process in the future.

Goal 2: Identify drug information resources; such as, Epocrates®, dosing aids, calculation aids, etc.

Goal 3: Develop a documentation plan for our contributions to patient care (i.e. interventions).

Over the past year, we have made progress on our goals and we are using PDA technology daily. We still have several projects to complete on the list, but we have started implementing our vision.

by Jean B. Douglas

Unlike computers, PDA's are portable and can be easily taken to the bedside and kept with you throughout the day. We purchased PDA's with the largest memory possible, wireless for faster data transfer, and color so that the white background will be easier to read on the floors and so the panic values will show up in the color red. We designated one desktop computer station in our Drug Information Center to handle the data archiving, database updates, and syncing. A pharmacy technician helps support these tasks.

To date, we have accomplished the following:

Goal 1: Moses Cone Health System chose the MData Enterprise System from MercuryMD® to deliver patient-specific information from the hospital's information systems to our pharmacists handheld devices. With this system, patients on the pharmacist's daily work list are presented with lab values, demographics, chief complaint, radiology reports, consults, medication list, etc. The pharmacist can go to the patient's data right on their handheld and pull up the latest information upon which to make drug-dosing decisions. Future features we are currently investigating include patient charging and documenting our daily notes, i.e. paperless.

Goal 2: Lexi-Drug from Lexicomp® was the drug information database found to be most useful by our pharmacists. While Epocrates® and other programs are fine, Lexi-Drug was found to be worth the fee. In partnership with MercuryMD®, Lexicomp® enabled Lexi-Drug to be "launched" directly from within MData, which saves time and optimizes the drug reference application. MedCalc 3.6®, PK-Dose 6.01®, and SynCalc® were added to the PDA's for calculations. Departmental employee phone numbers, physician phone/fax numbers, work schedule, MCHS formulary, etc. have also been added.

Goal 3: After reviewing several pharmacy intervention programs, Clinical Activity Log® by Pfizer was selected. From the initial template, a Cone-specific program was written. By using a Pendragon®-based database, the information can be downloaded into Access®. Data can be sorted and reports can be generated. The information can be entered quickly, without requiring time to write down specifics. This feature should become operational this year, after we complete the forms-collection component with more storage space in October.

The PDA project has provided us with time savings and efficiency in getting our labs and answering drug information questions. Physicians have noticed the pharmacists being in the patient care areas earlier in the mornings and they value this. In the past, the pharmacist was recording lab values on paper first. Additionally, the pharmacist can scan labs on all assigned patients to look for the 'red' panic values and prioritize these patients to be seen first. MercuryMD® has made a noteworthy difference for our pharmacists in that patient specific information is located on the PDA when needed. The most important outcome for us has been getting information from the PDA that our hospital data systems could not provide for us in a timely manner (i.e. >50% improvement in time to get labs). The drug information resource has allowed the pharmacist to answer greater than 90% of the questions asked in a quick manner, without having to return to the pharmacy to research the question. This has improved staff satisfaction.

Information you need to know before implementing such a program:

- PDA technology with the various programs can get expensive, especially when adding database and technical software. Purchase the most memory that you can. Technical support and a champion are most helpful during implementation. Consider HIPAA regulations when implementing your program, as well.
- Procedures need to be written for pharmacists who are technologically-challenged. They need to learn the difference in syncing and charging their units, in addition to other PDA functions.
- Acceptance by the pharmacist comes easy due to the time savings and ease of use.
- Staff will want to have these resources personally, so determine what the organization can and cannot provide for personal use (e.g. let pharmacists purchase hardware and software at hospital contract prices, etc.).

What does the future hold for PDA's in our practice?

We see the pharmacist entering patient specific information into the PDA on patient rounds, as well as getting information out of the PDA upon which patient decisions are made. At the end of the pharmacist's day, this PDA will be downloaded and key information will be extracted to determine the pharmacist's contributions, the number of patients seen, ADE's reported, outcomes achieved for disease management, charges to be submitted, etc. If all goes as planned, we are not that far away from having these services at our fingertips. The two major outcomes have been time savings for the pharmacist and pharmacist job satisfaction. ❖

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Wyeth Pharmaceuticals takes great pride in continuing the "Bowl of Hygeia" Award Program developed by the A. H. Robins Company to recognize pharmacists across the nation for outstanding service to their communities. Selected through their respective professional pharmacy associations, each of these dedicated individuals has made uniquely personal contributions to a strong, healthy community which richly deserves both congratulations and our thanks for their high example.

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Clinical Corner

Methylphenidate for Acute Depression

by Lorie Poole & Caisy Moore

Depression is a very common side effect of medical illness, especially in the hospitalized patient. Patients hospitalized for extended periods of time, including stroke victims, major surgery patients, and cancer victims, seem to be at even higher risks. Some of the signs and symptoms associated with depression include changes in appetite and/or weight loss, insomnia, fatigue, impaired immunity, and delayed wound healing.[1] Depression has been shown to delay patients' recovery time from a major illness and to decrease the likelihood of good outcomes.[2] Therefore, the expedient treatment of depression in this population could potentially decrease days of hospitalization, increase patients' quality of life, and decrease costs.

Depression is treated with tricyclic antidepressants (TCAs) like amitriptyline (Elavil®) and nortriptyline (Pamelor®), and selective serotonin re-uptake inhibitors (SSRIs) like fluoxetine (Prozac®) and sertraline (Zoloft®); however, due to the required two to three weeks needed to see benefits from these drugs, they are not always helpful for acute depression.[1-2] Because of the long response time associated with traditional antidepressants, some clinicians have turned to the use of psychostimulants, mainly methylphenidate (Ritalin®), to help bridge therapy.[1] Relief of symptoms of depressive signs and symptoms have been seen within 24 and 48 hours; however, possible side effects including tremor, nausea, and agitation may occur with initiation of treatment. Methylphenidate works by increasing the activity of norepinephrine and dopamine in the nerve synapse.

Although the dosing regimen for methylphenidate in acute depression has not been explicitly defined, it has been recommended that 2.5-5 mg PO in the morning and possibly a second dose at noon may be an initial regimen. The dose can be titrated by 2.5 mg increments to a maximum of 40 mg/day or until efficacy in the patient is seen.[3] Some clinicians may be apprehensive in using this agent due to methylphenidate's abuse potential and the possibility of tolerance, but in the studies reviewed by Frye et al no patients were removed from treatment due to abuse and none required dose increases due to tolerance.[1]

Due to the possibility of delayed wound healing and increased hospital stays, acute depression needs to be addressed in this population. When patients' depression symptoms have the potential to be detrimental to their care and recovery, rapid antidepressant action is crucial and a combination of methylphenidate and an SSRI may offer a transition regimen that allows for coverage while the SSRI takes effect. The possibility of starting methylphenidate for acute depressive symptoms, along with an SSRI for the long-term antidepressant effect is a possibility that seems to be safe and effective in this patient population, although more clinical studies are needed to demonstrate complete safety when using these drugs in combination.[3] ❖

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Bacterial Meningitis: *ACIP Recommendations and Vaccination in College Students*

by Michael Beisenherz

Meningitis is an infection of the fluid of the central nervous system and can be spread by either virus or bacteria. Common symptoms in anyone over two years of age include stiff neck, high fever, and headache. Viral infection, which results in a generally less severe illness than that caused by its bacterial counterpart, resolves without specific treatment. Conversely, bacterial meningitis can result in neurological damage, hearing loss, and even death. Before the routine use of the Hib vaccine in children, *H. influenzae* type b was the leading cause of bacterial meningitis. Today, the leading organism responsible in children and young adults is *N. meningitidis* (meningococcal disease), with *S. pneumoniae* still accounting for some cases each year.

Roughly 3000 cases of meningococcal disease occur in the United States annually, with a fatality rate of about 10%. Of the survivors, 10-20% have sequelae, including limb loss, hearing loss, and brain damage. Infants aged less than one year continue to experience the highest rate of the disease, however, new data reveals that college freshmen living in dormitories experience the second highest rate of infection. This phenomenon is reminiscent of the elevated rates of meningococcus among U.S. military recruits in the mid to late 1960's. These two groups have several common characteristics including age, diverse backgrounds, and crowded living quarters. Transmission occurs via throat and respiratory secretions (e.g. coughing, kissing), but fortunately not through casual contact.

Due to results from utilization analysis and the relatively low incidence of meningitis, routine vaccination of college students is unlikely to be cost-effective for the population as a whole. Furthermore, the vaccine is not always covered by third-party insurance. However, as a result of this new evidence, the Advisory Committee on Immunization Practices (ACIP) has modified its recommendations regarding the use of the meningococcal vaccine to prevent bacterial meningitis. Menomune®-A, C, Y, W-135, the quadrivalent vaccine manufactured by Aventis Pasteur, confers protection from each of the four serogroups listed. Between 1994-1998, approximately two-thirds of cases among those aged 18-23 years were caused by serogroups C, Y, and W-135, and could have been prevented through prior vaccination. It should be noted that the vaccine's protection is not 100% for the four strains, nor does it protect against serogroup B.

The vaccine is administered subcutaneously as a single 0.5-ml dose and is available in single-dose and 10-dose vials. The vaccine is well tolerated, with local pain at the injection site listed as the main side effect. Transient fever has been reported in up to 5% of patients. Revaccination may be indicated three to five years after the initial dose, if the patient is still at an increased risk, as antibody levels have been shown to drop substantially in the first three years.

The following are the current ACIP recommendations for meningitis vaccination in college students:

- Providers of medical care to incoming and current college freshman, especially those planning to live in residence halls, should inform these students and parents of the disease and the benefits of vaccination.
- College freshman who wish to reduce their risk for the disease should be either administered the vaccine or directed to a site where it is available.
- The vaccine can be administered to non-freshman undergraduates who wish to reduce their risk, even though the risk of meningitis in this population is similar to the general public.
- Colleges should inform freshmen, particularly those in residence halls, about the disease and the availability of a vaccine.
- Public health agencies should provide colleges and health care providers with this necessary information.

Routine vaccination is also recommended in certain high-risk groups. People who have terminal complement component deficiencies, and those who have functional or anatomic asplenia are candidates. Furthermore, those traveling in environments in which the disease is hyperendemic, such as the "meningitis belt" of sub-Saharan Africa that extends from Senegal to Ethiopia, should also be vaccinated.

A common question, as with most vaccines and pharmaceuticals, is whether the meningitis vaccine is safe and effective during pregnancy. Studies performed in pregnant women have not documented adverse events in either pregnant women or newborns. Therefore, adjusting the meningitis vaccination schedule during pregnancy is unnecessary.

The incidence of bacterial meningitis is relatively low which prevents routine vaccination from being cost-effective. At the same time, a safe and effective vaccine is available for those at high risk of infection, and for those who desire the added protection vaccination can confer. The decision is ultimately the patient's. With this established, it is the responsibility of public health services, colleges, and healthcare providers to fully inform patients of the disease and the currently available vaccine. ❖

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http://www.cdc.gov/ncidod/dbmd/diseaseinfo/#M

About the Author...

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November is National Diabetes Month

The Link Between Hemochromatosis and Diabetes

What is hemochromatosis?

Recently I was questioned about the link between hemochromatosis and diabetes. First of all, what exactly is hemochromatosis? Hemochromatosis is the most common genetic disorder in the United States. Approximately one out of every 200-300 Americans are affected by this disorder of iron metabolism. Hemochromatosis is characterized by excessive absorption of ingested iron, saturation of iron-binding protein, and deposition of hemosiderin in tissues. The tissues most commonly affected are the liver, pancreas, heart, skin, and joints. The conditions secondary to hemochromatosis in these organs are hepatomegaly and cirrhosis of the liver, diabetes, heart failure, bronzing of the skin, and arthritis.

What are some common signs and symptoms of hemochromatosis?

Early	Late
• fatigue	• gray or bronze skin pigmentation changes
• heart palpitations	• chronic abdominal pain
• joint pain	• severe fatigue
• nonspecific stomach pain	• risk of infections
• impotence	• cirrhosis of the liver
• amenorrhea	• liver cancer
• abnormal LFTs	• diabetes
	• hypopituitarism
	• pituitary function
	• gonadal function
	• heart disease or heart failure
	• joint disease

Who should be screened for hemochromatosis and how often?

According to the American Hemochromatosis Society 2000 guidelines, the following patient groups should be screened for hemochromatosis:

- everyone 18 years old and up; repeat testing performed every 1-2 years
- children ages 2-18 with diagnosed blood relatives: repeat testing every 2-3 years

What tests are involved in diagnosing hemochromatosis?

Screening for hemochromatosis involves a fasting iron panel consisting of serum iron, total iron binding capacity (TIBC), % of saturation, and serum ferritin. Patients should be told to skip iron supplementation for 24 hours before testing. Diagnostic analysis is indicated if the % saturation is greater than 40% and/or serum ferritin is greater than 150 ng/ml. DNA testing would then be indicated and may be performed using either a sample of tissue or blood.

To whom can I safely recommend iron supplementation?

The AHS guidelines strongly note that "no physician should prescribe iron supplements or vitamins containing iron or vitamin C without first determining the patient's iron storage status, as otherwise, the physician may be put at risk for medical negligence." ❖

About the Author...

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United We Stand

Third Annual NC Residents Leadership Conference

The morning of Friday July 19, 2002 dawned upon a large convergence of established and future pharmacy leaders at the Third Annual North Carolina Residents Leadership Conference held at Alamance Regional Medical Center in Burlington, NC. A meeting of minds and a melding of purpose was the course of the day for residents, residency directors, and attending speakers. More than an orientation, this conference called for pharmacists throughout North Carolina to stand united in vision for the future of pharmacy practice.

by Katherine Heller

After registration and refreshments, Fred Eckel, Executive Director of the North Carolina Association of Pharmacists (NCAP), and Michelle Fritsch of Alamance Regional Medical Center and Chair of NCAP's Residency Committee, warmly welcomed one and all. Fritsch opened the conference outlining the history and intent of the Residents Leadership Conference. Eckel expounded upon NCAP's vision for a united pharmacy directive.

Calling for united residency leadership, Janet Teeters, Director of Accreditation Services with ASHP, discussed the organization's vision for accredited residencies, the accreditation application process, and future developments regarding uniformity within the residency programs. Teeters personalized her professional development in pharmacy as well as how the vision of pharmacy is continuously being refined. Emphasizing uniformity with flexibility for residency programs, Teeters encouraged application for accredited residency development.

Fritsch and Stephen Kearney, Clinical Education Consultant for Pfizer, gave residents food for thought after Teeters' presentation with Pharmacy Bingo. This fun networking opportunity asked residents to greet and enlist twenty-five fellow residents to write on their bingo sheet. Requirements for each introduction included: name, location of practice, and one unique fact about the person. Ample time and opportunity abounded for friendly introductions and the beginnings of professional acquaintance.

Following lunch, the conference separated the residents and preceptors. Residents attended a Bayer College course on Writing for Excellence presented by Paul Casella. This program provided each attendant with a copy of the text *Writing, Speaking and Communication Skills for Health Professionals.* Casella outlined how he has worked with health care professionals to improve the clarity and effectiveness of medical writing. The take home message; keep it simple and state your main point clearly, concisely, and often.

While the residents attended the Writing for Excellence program, preceptors were busy attending Teeters' program "Residency and Accreditation Issues." The discussion centered around ASHP's 525 accredited residencies, 41% of which are specialized residencies and 59% of which are pharmacy practice residencies. ASHP plans to help develop uniformity in residency programs by categorizing them as "pharmacy practice residency with an emphasis in [*specific area of practice*]". Then any two-year residency would indicate a specialty residency. Ideally, ASHP hopes this streamlining will enable residencies applying for accreditation to adopt the focus for residency objectives to management and patient care. Additionally, this would allow all residencies to join the match.

After our respective presentations, the group returned en masse for a quick snack and break. Caffeinated and sugared, we once again separated for programs specific to our interests and level of expertise. Preceptors attended "Becoming a Clinical Leader" while residents attended "Developing a Research Project" by Kearney and Julie Ann Gouveia-Pisano, clinical consultant for Pfizer. This outstanding presentation clearly outlined a reasonable time line for development and completion of each phase of a research project. For objective development, Kearney recommended making the objectives RUMBA: Reasonable, Understandable, Measurable, Believable, Attainable. Residents won't forget their timely advice to "plan the work and work the plan!"

After a brief panel discussion moderated by Gouveia-Pisano, "Getting the Most from Your Residency," residents and preceptors gathered their books and belongings in anticipation of the drive home. Each of us left encouraged and we took the most important lesson home with us—to stand united in vision for the future of pharmacy practice. ❖

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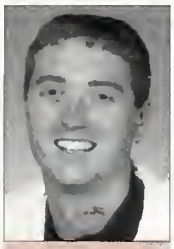
STUDENT VIEWS

A Younger Perspective on This Whole "Pharmacy Thing"



by Kyle Weant

Plato once wrote "the direction in which education starts a man will determine his future life." This timeless statement is just as valid today as it was over 2000 years ago. Not only does education determine the future of man, it also determines the direction man will take his profession. The future of the pharmacy profession lies in the hearts and minds of those who have yet to enter it. The education and experience that pharmacy students gain while in school will set the course of the pharmaceutical profession for years to come. If we are to change the profession for the better, we must start with those still in school and those just beginning their careers. To gather some insight into the future, I set out to interview several first and fourth-year pharmacy students, as well as new practitioners from the UNC School of Pharmacy. I asked them about their views and opinions of school, the profession, and the future.

My first question was the simplest of all, "why do you want to be a pharmacist?" Students are asked this constantly by friends and colleagues and to an extent it has become somewhat comical. However, this should not undermine its importance. The motivation for peoples' actions are just as important as the actions themselves. The impulse for entering the profession was fairly consistent among the pharmacy students interviewed. Most revolved around an interest in medicine accompanied by a desire to help people. The eternal question, however, is "what attracts students to pharmacy rather than other health care fields such as medicine?" The responses to this inquiry were similar to what one would expect; an interest in chemistry, an interest in having a family, and an interest in having more patient interaction. UNC graduate Lou Reynolds, a new practitioner, stated her motivation as one in which she wanted to "reach out to the patients, be an accessible health care provider…someone they could come too." A noble motivation for anyone in any profession.

I then asked what area of pharmacy students wanted to practice in when they graduated. Interestingly, the majority of those interviewed noted that they were more interested in entering a clinical position rather than a community one. Reasons for this included more flexibility and variety in the clinical field as well as not having to deal with irate customers or insurance. Most of the negative opinions linked to community pharmacy had to do with insurance and the volume of the workload rather than the actual job itself, as first-year student Minal Patel pointed out, "...[in community pharmacy] people blame you for insurance." But regardless of what area of practice students want to enter, all seem to desire jobs that involve a significant level of patient interaction. A prime example is Amy Citro, a fourth-year student who said, "I have felt that rotations with true patient contact and the ability to work on a health care team is much more reflective of what I hope to find in the workplace."

Students' opinions about what the most pressing issues are for the pharmacy profession today appeared to be associated with their concerns about community pharmacy. Most students felt that insurance and pharmaceutical care were the most important issues affecting our profession today. As Patel accurately noted, "[you are] expected to make the offer to counsel, but you are also supposed to be dealing with insurance and getting reimbursed." Thus, leading to a situation in which we may not have the time needed to realize our full potential as professionals. This was stated perfectly by forth-year student Jennifer Montgomery who said, "if we spent the time with patients that we needed to we could have a profound effect."

We as students realize that we have the knowledge, expertise, and skills to contribute significantly to the care of patients. However, if we are not allowed the time and support to provide that contribution then it is all for not. Students realize that this is a problem and something needs to change. At present, this seems to be a strong deterrent for students entering the field. Nevertheless, those that do enter community pharmacy are seeing an improvement as Reynolds observed, "we still have a ways to go…[but] people are starting to recognize how valuable our services are." In order to attract more students who put a high value on patient interaction to the community setting, more change is needed.

Do students feel they have a voice in this change, or do they feel that it is beyond their control? Those new to this profession can often provide a unique insight into it, one that those already surrounded by it may not see. All those interviewed feel that they

have a voice in the profession and play some role in determining the direction in which our profession is going. Several students noted participation in organizations as one avenue for having their voice heard but as Montgomery said, "it's up to you, you have to decide you want to."

Are students taking this initiative to try and have their voices heard? In terms of organizational participation, nearly all those interviewed were members of student or national organizations. This is by far not representative of the entire student body. Those willing to be interviewed were a more vocal and involved segment of the student population. The actual number of student members of ASHP or APhA resides somewhere around 50% of the entire student body at UNC's School of Pharmacy. Reasons cited for joining these organizations included everything from networking opportunities to receiving literature. Jennifer Stegall, a UNC graduate, said, "I feel that these organizations are necessary for disseminating new guidelines, ideas, and practice procedures to health care professionals as well as supporting our rights within the practice."

What remains unclear are the reasons why students are not members of organizations. Those that I have talked to cited reasons such as cost, time, and not viewing it as important. All of these reasons appear to have some merit. For students, cost and time are a highly valued commodity, and neither is very easily surrendered. A lack of understanding about the importance of active participation, however, is one that should not exist. The pharmacy profession is in the midst of a massive change. Anyone who is a part of this profession has a stake in this change and should have some voice in changing it. The difficulty in conveying this message appears to be systemic on both the student and practitioner levels.

I also asked students if there was anything they wished they had known, but didn't, before they entered pharmacy school? Interestingly, most students stated that they wish they had known more about the profession before they entered it. Several had never worked in a pharmacy before and regretted that lack of experience. Not having had active participation in the profession prior to matriculation appears to have put some students at a disadvantage. Second-year student Ann Phelps said, "It would have been nice to work in the actual pharmacy setting so you can work it into class." What is more interesting is the fact that with little prior knowledge of the profession and no work experience, these students still chose this profession as one that they wanted to practice for the rest of their lives. This can be interpreted as a very positive sign that the intrinsic appeal of our profession is great. A very small segment of the population is aware of the diversity of a pharmacist's potential jobs. If we were to increase public awareness of that diversity and of what we do as professionals, it then follows that the benefits could be endless.

Overall, students are aware of many of the current problems of the profession and see the necessity for change in resolving them. We are concerned about how to balance pharmaceutical care and dispensing as well as how to best manage insurance difficulties. More importantly, everyone interviewed believes that the profession is headed in the right direction and they are excited about their futures. In order to continue the change in the profession that has already begun, we need look no further than those currently in school. As students, we are the future of this profession but we need the guidance and support of those who have gone before us. While students are having their heads filled with pharmacy knowledge it is imperative that it is accompanied by a communication of the importance of professional involvement and a discussion of professional issues. With the proper influence, leadership, and guidance, we can make the future of our profession great. ❖

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Campbell University Pharmacy Convocation

The opening convocation for the Campbell University School of Pharmacy paid tribute to the late Gary Dunham, associate professor of pharmacy, and focused on the future of the School's 376 students. The service was held Wednesday, August 28 in Turner Auditorium on the Campbell campus.

Bringing greetings from professional organizations were NCAP President-elect Jack G. Watts, a member of the Campbell University Board of Trustees and past president of the North Carolina Board of Pharmacy, and NCAP President Ross W. Brickley. Both men urged students to "get involved" in their profession.

From left, Ronald Maddox, Dean of the Campbell University School of Pharmacy, Ruby S. Creech, W. Grover Creech, and Lib Fearing, wife of the late M. Keith Fearing.

"We as pharmacists can impact our patients' lives," Brickley said. "By getting involved politically we can mold policy throughout North Carolina and the US."

Keynote speaker for the event was Bob Sikora, vice president of the Clinical Education Consultant (CEC) Division of Pfizer, Inc. Sikora, whose background includes 30 years experience as a pharmacy educator, clinician, and director of pharmacies, also emphasized professional involvement in his remarks.

The M. Keith Fearing Award, given in memory of a Campbell alumnus who was a member of the School of Pharmacy's Founders' Committee and who established the first pharmacy in Dare County, NC, was also presented at the convocation service. Lib Fearing, wife of the late pharmacist, presented the award to W. Grover and Ruby Creech, owners of Creech Drug Company in Selma, NC.

Grover Creech graduated from the University of North Carolina at Chapel Hill's School of Pharmacy in 1954 and joined his brother, Joe Creech, as a partner and co-owner of Creech Drug Company. That same year, Creech helped organize the Johnston County Pharmacy organization and became its first president. He served a second term as the organization's president in 1984. ❖

NCAP PRESIDENT'S CLUB - 2002

The North Carolina Association of Pharmacists would like to thank the following individuals who supported our Association this year with financial contributions above and beyond standard membership dues.

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Small Doses

ASCP Elects New Officers

NCAP President Ross Brickley, of Garner, North Carolina, will serve as the American Society of Consultant Pharmacists' (ASCP) 2002–2003 president-elect. ASCP members elected Brickley during balloting this summer. He and other newly elected officers will be installed in November at Senior Care Pharmacy '02, ASCP's 33rd Annual Meeting and Exhibition in Anaheim, California.

Brickley, RPh, MBA, FASCP, CGP, is the director of pharmacy services for Neil Medical Group, a multistate provider of senior care services for more than 12,000 long-term care residents. He previously owned Hesston Pharmacy, a community-based, long-term care/retail pharmacy.

An ASCP member since1988, Brickley currently serves as ASCP vice president and chair of the ASCP DEA task force. Previously, he was chair of ASCP's Assisted Living/Community-Based Senior Care Action Network (SCAN) and served a term on the Board of Directors, acting as Board liaison to the Education Advisory Committee. Brickley has also served on the Professional Affairs and Public Affairs councils, as well as several other ASCP committees and task forces. He is a founding member and past president of the North Carolina ASCP Chapter, and has served three terms as chair of the chapter's Legislative Affairs Committee.

NCAP Member Participates in NCPA's Health Care Study

The role pharmacists can play in discovering men at risk for various diseases is the focus of a study being conducted by the University of Oklahoma College of Pharmacy (OU).

The study is part of the larger National Community Pharmacists Association (NCPA) Men's Health Care Initiative, which is supported by an unrestricted educational grant from Pfizer, Inc. The initiative focuses on educating men about their potential health risks and improving patient outcomes through community pharmacist interventions.

NCAP member Whit Moose of Moose Drug Company in Mount Pleasant, NC, is participating in this study. Pharmacists at 29 locations across the nation are screening men using the Men's Health Risk Assessment Tool (MHRAT).

Pharmacists at the study sites are assessing male patients using the MHRAT for common health risk factors and recommending that men at risk make an appointment for an examination by a physician. Researchers at OU will seek to determine patients' likelihood to follow through with the pharmacist recommendations for a physical examination and whether the patients need treatment for health risks that are discovered. Pharmacists will intervene with half of the men to see if intervention improves the likelihood for follow-through with a physical examination. The study also examines the economic impact on pharmacies offering this service.

C. U. Parents' and Awards Day


Kaye M. Dunham

The Campbell University School of Pharmacy held Parents' and Awards Day April 6, 2002. Senior Class President Kaye M. Dunham was the recipient of the North Carolina Association of Pharmacists Auxiliary Scholarship for 2002-2003.

Cooper's Pharmacy Receives "Pride of the Family" Award

Lewis Cooper, owner of Cooper's Pharmacy in Vass, NC, received the prestigious "Pride of the Family" Family Pharmacy Brand award from AmerisourceBergen Corporation at the company's Healthcare Conference and Expostion in Las Vegas last July. The award is presented annually to a pharmacy that has developed strong and successful programs to inform its employees and customers about the benefits of the Family Pharmacy private label brand of products. Cooper's Pharmacy was sited for its outstanding merchandising techniques and successful promotional programs.

Lockamy Reappointed to NC Medical Care Commission

Al Lockamy of Raleigh, NC was reappointed in September by Governor Mike Easley to serve a fifth term on the North Carolina Medical Care Commission. He is now the Senior Member of the Commission and will serve his four-year term by representing pharmacy aspects before the Medical Care Commission. The Commission approves tax free bonds for the plans and construction of hospitals, Area Health and Education Centers, nursing homes, extended living facilities, and emergency medical services. They also write rules and regulations which effect patient care in these areas. Al is employed at CVS Pharmacy on Six Forks Road in Raleigh. He feels it is a great honor to have the opportunity to serve not only pharmacy, but the citizens of North Carolina.

NCAP Members Serve and Enhance Medicap Pharmacies

Medicap Pharmacies, Inc. announced at their annual meeting that Lance Wheeler, PharmD, has been elected to the 2002-2003 Advisory Council. Lance's Medicap Pharmacy and medihealth solutions in Garner, NC is focusing many of its programs around cardiovascular disease. His pharmacy runs cholesterol screenings and has found the addition of natural medicine alternatives to his program to be beneficial.

Bobbie Barbrey, RPh, of Raleigh, NC is a newly elected member of the 2002-2003 Marketing Communications Committee for Medicap.

Jackie Harrell, of Medicap Pharmacy and medihealth solutions in Burlington, NC, was contacted by a local child care facility to provide Hepatitis B vaccinations to employees. By working with her protocol physician, Jackie was able to enhance her service offering and establish an even greater business demand for their services.

Randall Receives State's Highest Civilian Award

Because of his long list of community service, Bill Randall of Lillington received the state's highest civilian recognition from the office of the Governor. He was presented the Order of the Long Leaf Pine Award on September 18. Bill worked as a pharmacist for over 50 years and ran Lafayette Drug Store in Lillington. He continues to assist Campbell University as pharmacy manager of the student infirmary. ❖

2002 Calendar

Dec. 5: ***"A Prescription for North Carolina Seniors: More than Medicines"*** A Statewide Forum on Pharmaceutical Care for Older Adults, 8:30 am – 4:40 pm, The Friday Center, Chapel Hill, NC. To register, or for more information visit the Senior PHARM*Assist* Web site at www.seniorpharmassist.org or call (919) 688-4772. ACPE credits will be available. Early registration is encouraged due to limited seating.

April 8-9, 2003: ***NCAP Spring Meeting***
Sheraton Four Seasons, Greensboro, NC. For more information call 919.967.2237 ext. 22 or visit the NCAP Web site at www.ncpharmacists.org

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